Wisconsin Medicaid Program
Inpatient Hospital State Plan
Method and Standards For Determining Payment Rates
With Amendments Effective July 1, 2007

***** TABLE OF CONTENTS *****

Wisconsin Medicaid Program
Inpatient Hospital State Plan
Method and Standards For Determining Payment Rates

SECTION 1000
OVERVIEW OF INPATIENT HOSPITAL REIMBURSEMENT

This section is a brief overview of how reimbursement to hospitals is determined for inpatient services that are provided by hospitals to eligible recipients of the Wisconsin Medicaid Program (WMP). The WMP uses a reimbursement system which is based on Diagnosis Related Groupings (DRGs). The DRG system covers acute care hospitals. Excluded from the DRG system are rehabilitation hospitals, State Institutions for Mental Disease (IMDs) and psychiatric hospitals, which are reimbursed at rates per diem. Also, reimbursement for certain specialized services are exempted from the DRG system. These include acquired immunodeficiency syndrome (AIDS), ventilator-assisted patients, unusual cases and brain injury cases. Special provisions for payment of each of these DRG exempted services are included in the plan. As of July 1, 1995, organ transplants are covered by the DRG system.

The WMP DRG reimbursement system uses the grouper that has been developed for and used by Medicare, with enhancements for certain perinatal, newborn and psychiatric cases. The grouper is a computer software system that classifies a patient's hospital stay into an established diagnosis related group (DRG) based on the diagnosis of and procedures provided the patient. The WMP applies the Medicare grouper and its enhancements to Wisconsin-specific claims data to establish a relative weight for each of over 550 DRGs based on statewide average hospital costs. These weights are intended to reflect the relative resource consumption of each inpatient stay. For example, the average hospitalization with a DRG weight of 1.5 would consume 50 percent more resources than the average hospitalization with a weight of 1.0, while a hospital stay assigned a DRG with a weight of .5 would require half the resources.

Each hospital is assigned a unique "hospital-specific DRG cost based payment per discharge". The provider specific, cost based DRG payment rate will be adjusted by case mix with additional payments made for eligible outlier cases.

Given a hospital's specific DRG rate and the weight for the DRG into which a stay is classified by the grouper, payment to the hospital for the stay is determined in multiplying the hospital's rate by the DRG weight.

A "cost outlier" payment is made when the cost of providing a service exceeds a pre-determined "trimpoint". Each inpatient hospital claim is tested to determine whether the claim qualifies for a cost outlier payment. A length-of-stay outlier payment is available upon a hospital's request for children under six years of age in disproportionate share hospitals and for children under age one in all hospitals.

For additional information, contact:

Hospitals, Physicians and Clinics Section
Division of Health Care Financing
1 W. Wilson Street, Room 350
P. O. Box 309
Madison, Wisconsin 53701-0309.

Telephone (608) 261-7838
FAX Telephone (608) 266-1096
Voice/TDD 1-800-362-3002

SECTION 2000
STATUTORY BASIS

The Wisconsin inpatient hospital payment system is designed to promote the objectives of the State statutes regarding payment for hospital services (Chapter 49, Wis. Stats) and to meet the criteria for Title XIX hospital payment systems contained in the Federal Social Security Act and Federal Regulations (Title 42 CFR, Subpart C). The inpatient payment system will comply with all applicable Federal and State laws and regulations and will reflect all adjustments required under these laws and regulations.

****

SECTION 3000
DEFINITIONS

Annual Rate Update. The process of annually adjusting hospital payment rates to be effective July 1 of each year based on more current cost reports and/or other information relevant to hospital reimbursement.

Border Status Hospital. A hospital not located in Wisconsin which has been certified by the WMAP as a border-status hospital to provide hospital services to WMAP recipients. (Reference, HFS 105.48, Wis. Adm. Code) Border status hospitals are differentiated between major border status providers and minor border status providers as described in Section 3520.

Children's Hospital. Acute care hospital whose primary activity is to serve children.

Department. The Wisconsin Department of Health and Family Services (or its agent); the State agency responsible for the administration of the Wisconsin Medical Assistance Program (WMAP).

DRG. DRG means Diagnosis Related Groups which is a patient classification system that reflects clinically similar groupings of services that can be expected to consume similar amounts of hospital resources.

Hospital-Specific DRG Cost Based Payment Rate. The payment rate per discharge which will be calculated for and assigned to each hospital by the Department for the rate year. This is the rate by which a DRG weight is multiplied to establish the amount of payment for an individual inpatient stay. Hospital-Specific payment rates are based on individual provider costs adjusted to ensure compliance with the Department's annual budget.

IMD. Institution for Mental Disease, as defined in 42 CFR 435.1009. When used in this Plan, IMD means "hospital IMD".

Long Term Care Hospital. An acute care hospital reimbursed by Medicare under the Medicare prospective payment system for long-term care hospitals (LTCH).

Medicaid Management Information System (MMIS). The system used to process provider claims for payment.

Non-Border Status Hospital. A hospital not located in Wisconsin and which has not been certified by the WMAP as a border status hospital.

Prospective Rate per Diem. The hospital-specific rate for each day of service.

Rate Year. The twelve month period from July 1 through June 30 during which rates established under the annual rate update are to be effective for most, if not all, hospitals.

Rehabilitation Hospital. A hospital that provides intensive rehabilitative services for conditions such as stroke, brain injury, spinal cord injury, amputation, hip fractures, and multiple trauma to at least 75% of its patient population. IMD hospitals cannot be considered rehabilitation hospitals under the provisions of this plan.

WMAP. Wisconsin Medical Assistance Program, also referred to as Medicaid, Medical Assistance (MA) or Title XIX.

****

SECTION 3500
DIFFERENCES IN RATE SETTING BETWEEN IN-STATE HOSPITALS AND OUT-OF-STATE HOSPITALS

3510 Hospitals Located in Wisconsin

General hospitals and most specialty hospitals located in Wisconsin (in-state hospitals) are reimbursed according to the DRG based payment method described in section 5000 herein. All inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000. As of July 1, 1995, organ transplants are paid under the DRG based payment method.

Certain specialty hospitals are reimbursed under a rate per diem methodology, not the DRG based payment system. Rehabilitation hospitals as defined in section 3000 are paid a per diem rate according to section 6300. State mental health institutes are paid under the payment rates described in section 6210. All other psychiatric hospitals are paid under the payment rates described in section 6230.

Administrative Adjustment of Rates. In-state hospitals may request an administrative adjustment to their payment rates under the criteria described in section 11000. The due dates for requesting adjustments are described in that section.

Use of Cost Report In Rate Setting. An in-state hospital's audited cost report is required for establishing certain components of the hospital's specific payment. The specific components include the cost based amount per discharge (§5100) and outlier payments (§5200). In addition, cost report information is also used for disproportionate share hospital payments (§5180).

3520 Hospitals Not Located In Wisconsin and Border Status Hospitals

Hospitals not located in Wisconsin which provide inpatient services to WMAP recipients may be reimbursed for their services. Certain of these hospitals have been granted "border status" by the WMAP. Others do not have border status under the WMAP (non-border status hospitals).

Non-Border Status Hospitals. Out-of-state hospitals which *do not have border status* are reimbursed under the DRG based payment method described in section 10000 herein. Payment is based on a standard DRG base rate.

All non-emergency services at out-of-state hospitals which do not have border status require prior authorization from the WMAP. This differs from the prior authorization requirements for in-state and border status hospitals.

Minor Border Status Hospitals. Border status hospitals are divided into minor and major border status hospitals. Minor border status hospitals are those border status hospitals which do not meet the criteria described below for a major border status hospital. Minor border status hospitals are reimbursed according to section 10000 in the same manner as non-border status hospitals and may request the administrative adjustments to payment rates as described in that section.

Major Border Status Hospitals. Major border status hospitals are reimbursed according to the DRG based payment method described under section 5000. This is the same DRG method as is used for in-state hospitals; it provides a hospital specific cost based rate. However, Major Border Status Hospitals are subject to a different budget reduction factor than in-state hospitals.

Administrative Adjustments To Rates. Major border status hospitals may request administrative adjustments to their payment rates under section 11000.

Use of Cost Report In Rate Setting. As described in section 4000, a major border status hospital must submit a current audited cost reports to the Department for establishing their payment rate. The cost report is used to determine the cost specific to treating Medicaid recipients as descried in Section 5160. Major Border Status Hospitals are eligible to receive outlier payments as described in section 5200.

Criteria For Major Border Status. Major border status hospitals are those border status hospitals which have had 75 or more WMAP recipient discharges or at least $350,000 or greater inpatient charges for services provided to WMAP recipients for the combined two rate years ending in the calendar years preceding the current annual rate update. Not included in these amounts are discharges and charges for: (1) Medicaid HMO covered stays, (2) stays which were paid in full or part by Medicare, (3) stays paid in full by a payor other than Medicare or Medicaid. Paid in full means the amount received by the hospital equals or exceeds the amount the WMAP would have paid for the stay. For each rate year, the Department will assess the discharges and charges of each border status hospital and notify the hospital of its standing as a major or minor border status hospital. For example, the following table shows the years used for a series of annual rate updates.

Annual Rate Update Effective Date	Rate Years Looked At for Discharges and Charges
July 1, 1996	July 1993 to June 1994 and July 1994 to June 1995
July 1, 1997	July 1994 to June 1995 and July 1995 to June 1996

Rehabilitation Hospitals With Border Status. A major border status hospital which the Department determines qualifies as a rehabilitation hospital, as defined in section 3000, will be reimbursed on a prospective rate per diem according to section 6300 otherwise the hospital will be paid under the DRG based payment method of section 5000. A minor border status rehabilitation hospital may request payment at a rate per diem according to section 10469.

Alternative Payments To Border Status Hospitals For Certain Services . For any out-of-state acute hospital, border status or not, all inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000.

SECTION 4000
COST REPORTING

4010 General
Every in-state hospital participating in the Wisconsin Medical Assistance Program (WMAP) will prepare a Title XIX cost report. The Wisconsin Medical Assistance Program uses the Medicare cost reporting form for its Title XIX cost report. Major border status hospitals will submit their audited Medicare cost reports. Hospitals will be instructed regarding any supplemental worksheets and additional information that may be specifically required by the WMAP.

4020 Cost Report Due Date

4021 In-State Hospitals.
In-state hospital providers must submit their initial Medicare cost report and accompanying supplemental schedules to the Department or its agent at the same time it submits its initial Medicare (Title XVIII) cost report to its Medicare intermediary. When hospitals receive a notice of provider reimbursement (NPR) from Medicare or a Medicare audit intermediary, the hospitals must submit the report to the Department or its agent the Medicare cost report on which NPR is based within sixty (60) days of the NPR date. If the hospital is pursuing any appeal of the audited Medicare cost report, the hospital should submit the audited cost report to the Department along with a description of the items being appealed. The Department's address for submitting cost reports is:

Hospitals, Physicians and Clinics Section,
Division of Health Care Financing,
P. O. Box 309,
Madison, WI 53701-0309.

4022 Major and Minor Border-Status Hospitals.
Both major and minor border-status hospitals must submit Medicare audited cost reports to the Department within sixty (60) days of the Medicare audit being completed. A hospital not participating in the Medicare program should submit the cost report it provided the Medicaid program in its state. An audit should be considered completed upon the hospital receiving the Medicare audit report. If the hospital is pursuing any appeal of the audited Medicare cost report, the hospital should submit the audited cost report to the Department along with a description of the items being appealed. The Department's address for submitting cost reports is:

Hospitals, Physicians and Clinics Section,
Division of Health Care Financing
P.O.Box 309
Madison, WI 53701-0309.

Audited Cost Report Used In Rate Setting. For major border-status hospitals, the Department uses a hospital's audited cost report on file with the Department to establish rates. If that cost report is for a fiscal year that is more than three years old, the hospital can request an administrative adjustment for use of a more current cost report in rate setting. Such an administrative adjustment is discussed under section 11900, item B.

4030 Gains and Losses of Depreciable Assets
Depreciable assets may be disposed of through donation, sale, scrapping, demolition, abandonment or involuntary conversion such as condemnation, fire, theft or other casualty. The gain or loss on such a disposition is not recognized for reimbursement under the Wisconsin Medicaid Program. This means that for dispositions occurring after June 30, 2004 the WMP will not recover a portion of any gains and will not provide supplemental payments for a portion of the losses.

Depreciable assets may be disposed of and replaced with depreciable assets through trade-in or exchange or, in the case of facilities and land improvement, demolition to clear land for use by or adjacent to replacement facilities. The gain or loss on such disposed assets is to be recognized in the capitalized cost of the replacement assets in accord with generally accepted accounting principals.

4040 Allowed Capital Cost Upon Change of Ownership

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness with respect to an asset of a hospital which has undergone change of ownership, Medicare allowable cost principles now in effect or as may be amended govern the allowableness of costs except when provisions of this plan specifically describe a variance from Medicare principles.

SECTION 5000
DRG BASED PAYMENT SYSTEM
FOR IN-STATE HOSPITALS AND MAJOR BORDER STATUS HOSPITALS

5010 INTRODUCTION

A hospital is paid a prospectively established amount for each discharge under the DRG based payment system. In the Department's annual rate update, a "provider specific, cost based DRG payment rate adjusted by case mix" is calculated for each hospital. This rate is the result of utilizing the most recently available audited Medicare cost report data reported by the Centers for Medicare and Medicaid Services (CMS) within the Health Cost Report Information System (HCRIS) data set . Medicare and Medicaid cost principles are used to calculate the provider specific base DRG payment rate.

For each Medicaid recipient's stay, a hospital's specific DRG cost based payment rate is multiplied by the relative weighting factor for the diagnosis related group (DRG) which applies to the hospital stay. The result is the DRG payment to the hospital for the specific stay. In addition to the DRG payment, an "outlier" payment may be made to the hospital for very high cost cases which are described in sections 5221 through 5224 or for certain very long lengths of stay which are described in sections 5231 through 5234. Also, qualifying hospitals may receive a disproportionate share payment adjustment to the DRG payment rate as described in section 5180.

5020 HOSPITALS COVERED BY SECTION 5000

Acute care and children hospitals and major border status hospitals will be paid according to the DRG based payment system described in section 5000. Payment for Critical Access Hospitals is covered by section 5400. Minor border status hospitals, out-of-state non-border status hospitals, rehabilitation hospitals, psychiatric hospitals, State operated IMD hospitals and veteran hospitals are not covered by section 5000.

5030 SERVICES COVERED BY DRG PAYMENTS

All covered services provided during an inpatient stay, except professional services described in §5040, shall be considered hospital inpatient services for which payment is provided under this DRG based payment system. (Reference: Wis. Admin. Code, HFS 107.08(3) and (4))

All inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000.

As of July 1, 1995, organ transplants are covered by the DRG based payment method.

5040 PROFESSIONAL SERVICES EXCLUDED FROM DRG PAYMENTS

Certain professional and other services are excluded from the DRG payment system. Professional services must be billed by a separately certified provider and billed on the CMS - 1500 claim form. The following services are excluded, when the professionals are functioning in the capacity of:

Physicians	Optometrists	Pharmacy, for take home drugs on the date of discharge
Psychiatrists	Hearing aid dealers	
Psychologists	Audiologists	Durable medical equipment and supplies for non-hospital use
Physician assistants	Podiatrists	
Nurse midwives	Independent nurse practitioners	Specialized medical vehicle transportation
Chiropractors	Anesthesia assistants	
Dentists	Certified registered nurse anesthetists	Air, water and land ambulance

5100 STANDARDIZED DRG PAYMENT FACTORS

Certain standard factors are used in the determining the amount of payment hospitals receive for services covered by the DRG based payment method. The Department adjusts these standard factors for each rate year, July 1 through June 30. They include the DRG grouper and the DRG weights.

5120 DRG Grouper

The DRG grouper is a patient classification software system which results in a patient stay being classified into one "diagnosis related group" (DRG). The WMP DRG reimbursement system uses the grouper developed for Medicare based on "major diagnostic categories" (MDCs). For newborns, WMP has enhanced the grouper's MDC 15, Newborns and Other Neonates with Conditions Originating in the Perinatal Period. For psychiatric stays, the grouper's MDC 19, Mental Diseases and Disorders, is also enhanced.

Annually, beginning with July 1, 1992, updated versions of the Medicare grouper will be used by the WMP. The Medicare grouper version, which is released by CMS for use by Medicare beginning on October 1 of each calendar year, will be implemented for MA discharges occurring on and after July 1 of the subsequent calendar year. (For example, on October 1, 1991 CMS began to use Version IX of the Medicare grouper. Therefore, for dates of discharge on and after July 1, 1992, the WMP will apply that Version IX grouper.)

5130 DRG Weights

DRG weights reflect the relative resource consumption of each inpatient stay. The weights are determined from an analysis of past services provided by hospitals, the claim charges for those services and the relative cost of those services. WMP recipient inpatient hospital claims are used in order that the weights which are developed are relevant to the types and scope of services provided to WMP recipients.

Annually, beginning with July 1, 1992, revised DRG weights will be established based on (1) the updated version of the Medicare grouper, (2) more current claims information and (3) more current inpatient hospital cost report information.

DRG weights in effect for the year July 1, 2005 through June 30, 2006 are applied in the rate year July 1, 2006 through June 30, 2007. Sections 5130.1 through 5130.3 are not applied for rate year July 1, 2006 through June 30, 2007.

5130.1 Claims Used. Claims for a period of at least three years for WMP certified hospital providers in Wisconsin are used. The selected period of claims is not to end more than twenty-four months nor less than nine months prior to the July 1st day on which the revised DRG weights are to be implemented. Claims not covered by WMP's DRG based payment system are not used. These are claims for which payment is made at rates determined under Sections 6000 and 7000. Also not used are claims from any hospital designated a critical access hospital (CAH) during the selected period of claims. This exclusion of claims applies to hospitals newly designated as a CAH or discontinued as a CAH anytime during the selected period of claims.

5130.2 Cost Report Used. The WMP uses the cost report for each hospital's most recently completed reporting period for which an audit adjusted cost report is available to the Department as of the February 28th date prior to the July 1st day on which the revised DRG weights are to be implemented. The Department will use the HCRIS database as the primary data source. Costs are inflated as described below for the calculation of weights.

5130.3 Weights Calculated.

The updated version of the Medicare grouper described in section 5120 above is applied to the historical claims from the period described in subsection 5130.1 above. Each claim is classified to and assigned its appropriate diagnosis related grouping (DRG) by the grouper.

The cost of each inpatient hospital claim is calculated. This is a hospital-specific claim cost that requires correlating the services charged on the claim to related cost centers of the hospital's cost report. For each claim, accommodation charges for the hospital stay are multiplied by the cost-to-charge ratio of accommodation cost centers in the respective hospital's cost report. The result is the cost of accommodations for the hospital stay. Ancillary service charges are multiplied by the cost-to-charge ratio of ancillary cost centers in the respective hospital's cost report providing a cost for ancillary services. Acquisition charges for transplanted organs are multiplied by cost-to-charge ratios for the respective organ. The resulting accommodation cost, ancillary service cost and organ acquisition costs of each claim is summed resulting in the total cost of the inpatient stay.

The cost of each inpatient stay is further standardized (or adjusted) for area wage differentials and reduced for the cost attributed to capital costs, direct medical education costs and outlier costs.

Each claim's cost is inflated by an inflation multiplier to the current rate year. The inflation multiplier is derived from indices in the publication, "Health-Care Cost Review", that is published quarterly by Global Insight, Inc. Specifically used are the total market basket indices from the tables entitled "CMS Hospital Prospective Reimbursement Market Basket."

The average cost of the claims by each DRG is calculated. Also, a combined overall average cost of all DRG claims is calculated. The weight for each respective DRG is the average cost of the respective DRG's claims divided by the combined overall average cost. In this way, weights are established for over 550 DRGs.

Random anomalies and incongruities in the resulting weights are reviewed and analyzed in the light of the prior year weights and the cost and volume of claims involved. The questioned DRG weights are adjusted, if considered appropriate, to a reasonable amount based on the analysis. It should be noted that low-volume DRGs are especially vulnerable for significant year-to-year swings in their weight. A significant decrease in the weight of any individual DRG is limited unless cost, volume and central tendency and deviation data justify the significant decrease. A listing of the resulting proposed and final DRG weights are disseminated to in-state and major border status hospitals.

5130.4 Cochlear Implants.
A separate weighting factor is provided for inpatient hospital stays for cochlear implants. Payment is available upon written request by the hospital for payment at this weight and is only available for a claim that covers cochlear implant surgery and the cost of the apparatus. This is a low volume inpatient procedure for Medicaid recipients but is significantly more expensive than the broadly inclusive DRG #49, major head and neck procedures, in which cochlear implants are grouped (assigned). A claim for surgery without the apparatus cost will be covered under DRG #49. The cochlear implant weight was established based on the cost of 17 inpatient stays from February 1991 to August 1993. This set of claims covered some WMP recipients but mostly persons not covered by WMP. When a sufficient number of inpatient claims from a current period of no more than 7 years is available for WMP recipients receiving cochlear implants, a weight will be calculated based on those claims. The method of calculating a weight is that described above for other weights.

5140 DRG Weights For MDC 15, Mental Diseases and Disorders

The WMP has expanded the nine standard diagnosis related groupings (DRGs) of MDC 15 for Mental Diseases and Disorders. For each of the DRGs, separate weighting factors are constructed for two age ranges: (1) over age 17 and (2) age 17 and younger. The result is 18 weighting factors. These weighting factors apply to hospital stays for mental diseases and disorders in acute care hospitals. The DRG Weights do no apply to hospital institutions for mental disease (IMDs) including State operated, and Psychiatric providers.

As noted in subsection 5130.3, random anomalies and incongruities in the resulting weights are reviewed and adjustments made if considered appropriate.

5150 Provider Specific Payment Rates for Hospitals Located within the State of Wisconsin

A hospital-specific cost based DRG payment is derived by determining the allowable Medicaid costs for services provided. This rate is derived by examining cost report data from the Medicare 2552-96 cost report form. The Department uses Medicare and Medicaid cost principles to determine the allowable costs for each provider for routine inpatient hospital services. For ancillary services, a cost to charge ratio is calculated to determine the cost for inpatient ancillary services. The result of this calculation is a provider specific cost based DRG payment rate. This rate is then adjusted for case mix. Specifically the Department calculates the case mix index for each provider based upon historical Medicaid claims data. The Department will utilize the claims data from the Medicaid Management Information Systems (MMIS) corresponding to the cost report year used to derive the provider specific cost based payment rates. The provider specific payment rate adjusted for case mix is the standard DRG payment rate for a DRG weight of one (1.00). A uniform budget adjustment factor will be applied to each in-state hospital's rate to assure compliance with the Department's budget.

5160 Provider Specific Payment Rates for Major Border Status Hospitals Located Outside the State of Wisconsin

A hospital-specific cost based DRG payment is derived by determining the allowable Medicaid costs for services provided. This rate is derived by examining cost report data from the Medicare 2552-96 cost report form. The Department uses Medicare and Medicaid cost principles to determine the allowable costs for each provider for routine inpatient hospital services. For ancillary services, a cost to charge ratio is calculated to determine the cost for inpatient ancillary services. The result of this calculation is a provider specific cost based DRG payment rate. This rate is then adjusted for case mix. Specifically the Department calculates the case mix index for each provider based upon historical Medicaid claims data. The Department will utilize the claims data from the Medicaid Management Information Systems (MMIS) corresponding to the cost report year used to derive the provider specific cost based payment rates. The provider specific payment rate adjusted for case mix is the standard DRG payment rate for a DRG weight of one (1.00). This is the same DRG method as is used for in-state hospitals; it provides a hospital specific cost based rate. However, Major Border Status Hospitals are subject to a different budget reduction factor than in-state hospitals.

5170 Rural Hospital Adjustment Percentage

5171 Qualifying Criteria.

A hospital may qualify for a rural hospital adjustment if it meets the following conditions. Administrative adjustments regarding qualifying for the rural hospital adjustment and the adjustment percentage are described in section 11900, items I, J and K. Critical access hospitals under section 5400 are not eligible to receive an adjustment under this section.

1. The hospital is located in Wisconsin, is not located in a CMS defined metropolitan statistical area (MSA), and has the WMP's Wisconsin rural area wage index used in calculation of its hospital-specific DRG base rate.
2. As of January 1, 1991, the hospital was classified in a rural wage area by Medicare.
3. The hospital is not classified as a Rural Referral Center by Medicare.
4. The hospital did not exceed the median amount for urban hospitals in Wisconsin for each of the following operating statistics for the statistical years described below: (a) total discharges excluding newborns, (b) the Medicare case-mix index, and (c) the Wisconsin Medicaid case-mix index.
5. For rate years beginning on and after July 1, 1998, the combined Medicare and Medicaid utilization rate of the hospital is determined to be equal to or greater than 50.0%. For rate years beginning prior to July 1, 1998, the combined Medicare and Medicaid utilization rate has been equal to or greater than 55.0%.

For criteria item 4 above. The statistical year for total discharges excluding newborns will be the fiscal year of the hospital. The statistical year for the Wisconsin Medicaid case-mix index will be the state fiscal year. The statistical year for the Medicare case-mix index will be the federal fiscal year. The fiscal year to be used is that fiscal year which ended in the second calendar year preceding the annual July 1 rate update. (For example, for July 1, 1996 rate updates, the statistical years will be fiscal years that ended in 1994.) Urban hospital means any hospital located in Wisconsin which is located in a HCFA defined metropolitan statistical area (MSA) or which has a WMAP urban area wage index used in calculation of its hospital-specific DRG base rate.

For criteria item 5 above. The combined Medicare and Medicaid utilization rate is determined by dividing the total Medicare and Medicaid inpatient days by the total inpatient days. Long-term care days from hospital swing-beds shall not be included as inpatient days in this calculation. The inpatient days will be from the individual hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may at its option use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. If the audited cost report which is used is more than three years old, the hospital may request an administrative adjustment under §11900, item B, to have its rural adjustment based on a more current audited cost report. For the base cost reports to be used for hospitals combining operations, see section 5280.

5172 Adjustment Percentage.

The amount of the rural hospital adjustment is based on a qualifying hospital's Medicaid utilization rate. The Medicaid utilization rate is determined by dividing the total Medicaid inpatient days by the total inpatient days from the individual hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may at its option use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. Long-term care days from hospital swing-beds shall not be included as inpatient days in the denominator of this calculation.The resulting Medicaid utilization rate is used to determine the adjustment percentage for the hospital-specific DRG base rate according to the table in appendix section 25000. The rural hospital adjustment percentage is that percentage corresponding to the range of utilization percentages in which the individual hospital's Medicaid utilization rate falls.

The Department has determined that a total of $2,256,000 will be available for the Rural Hospital adjustment (for all hospitals combined) in FY2008 and years thereafter The adjustment percentage to the hospital specific DRG base rate shall be proportionately reduced, if necessary, to comply with this Rural Hospital adjustment budget. For example, if all DSH adjustments must be reduced by 10% to comply with the $2,256,000 limit, a 5% rate add-on will be reduced to a 4.5% rate add-on.

NOTE: To clarify for the federal Center for Medicare and Medicaid Services (CMS), the adjustment described in the above section 5170, specifically subsections 5171 and 5172, is NOT a disproportionate share hospital (DSH) adjustment under Section 1923 of the Social Security Act.

5180 Disproportionate Share Adjustment Percentage

5181 General.

The special payment adjustment described in this section 5180, specifically subsections 5181 through 5186, are disproportionate share hospital payments provided in accord with the federal Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923.

Rate adjustments are allocated to hospitals that provide a disproportionate share of services to Medicaid and low-income patients. A hospital may qualify for a disproportionate share adjustment if the hospital's Medicaid utilization rate is at least 1% and if either (1) the hospital's *Medicaid utilization rate* is at least one standard deviation above the mean Medicaid utilization rate for hospitals in the State, or (2) has a *low-income utilization rate* of more than 25%.

5182 Obstetrician Requirement.

In order for a qualifying hospital to receive its adjustment, it must have at least 2 obstetricians who have staff privileges and who have agreed to provide obstetrical care to WMAP recipients. Hospitals may substitute any physician with staff privileges to perform obstetrical care and who has agreed to provide care to WMAP recipients. If a hospital serves patients predominantly under age 18, or if the hospital did not offer non-emergency obstetrical care as of December 21, 1987, it need not comply with this obstetrical requirement in order to receive the adjustment.

5183 Medicaid Utilization Method

A hospital with high Medicaid utilization may qualify for a disproportionate share hospital (DSH) adjustment. The DSH adjustment under this "Medicaid utilization method" is provided to hospitals in the Department's annual DRG rate update. A hospital's DSH adjustment is incorporated into the hospital's specific DRG base rate and ultimately into the payment a hospital receives for each Medicaid recipient's stay.

Statewide Amounts Calculated: The Department annually calculates a "Medicaid inpatient utilization rate" for each hospital in the state that receives Medicaid payments. This is M in the following formula. From the compilation of the individual hospital utilization rates, the statewide mean average and standard deviation from the mean are calculated. The mean rate plus the amount of one standard deviation is S in the following formula.

Qualifying Hospital Under Medicaid Utilization Method: A hospital qualifies for a DSH adjustment if its Medicaid inpatient utilization rate (M) is equal to or greater than the mean-plus-one-standard-deviation (S) and is at least 1%.

Hospital Specific Adjustment Calculated: A "DSH adjustment percentage" is calculated according to the following formula for a hospital that qualifies under the Medicaid utilization method.

[(M minus S) x F] + 3% where M = Hospital's Medicaid inpatient utilization rate
S = Statewide mean-plus-one-standard-deviation
F = Proportional increase factor

This adjustment factor will be applied to either the DRG base rate or per diem rate, depending on the method of payment Medicaid uses for the eligible hospital type. The amount of the DSH add-on shall be limited by budgetary restrictions as outlined in sections 5184.

Adjustment for Certain IMDs. The above 3% factor is increased to 11% for any hospital institution for mental disease (IMD) which qualifies for a disproportionate share hospital adjustment and has an average length of stay that exceeds 35 days for Wisconsin Medicaid recipients. Any days of a Medicaid recipient's stay that are covered in whole or part by Medicare are excluded from the calculation of the average length of stay. The average length of stay is based on the rate year that ended in the calendar year preceding the calendar year in which the current rate year begins. For example, for rates effective July 1, 1996, the base will be the rate year July 1, 1994 to June 30, 1995.

Medicaid Inpatient Utilization Rate. For purposes of the above calculation, the term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for Medicaid, and the denominator of which is the total number of the hospital's inpatient days.

Medicaid inpatient days (the numerator) will include Medicaid HMO recipient days and recipient days of other states' Medicaid programs reported by a hospital.

Medical Assistance patient days in the numerator shall not include any days of inpatient stays which were covered in full or part by Medicare. Paid in full means the amount received by the hospital equals or exceeds the amount WMAP would have paid for the stay.

Some MA recipient stays, which are not covered in full or part by Medicare, may be paid fully or partially by a third party insurance payor and\or by a recipient's MA eligibility spend-down funds. If the hospital stay is paid in full, then the days of the recipient's stay will not be included in the numerator as an MA patient day. If the hospital is not paid in full and the WMAP reimburses the hospital for the unpaid balance, then all days of the stay will be included in the numerator as an MA patient day to the extent that the days of the stay were allowed by the WMAP.

Base Data For In-State Hospitals. For hospitals located in Wisconsin, the number of total inpatient days, MA inpatient days and MA HMO inpatient days will be from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update except the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. If the audited cost report which is used is more than three years old, the hospital may request an administrative adjustment under §11900, item B, to have its disproportionate share adjustment based on a more current audited cost report. The statewide mean Medicaid utilization rate and the standard deviation amount will not be recalculated to include the MA utilization rate resulting from the administrative adjustment. For the base cost reports to be used for hospitals combining operations, see section 5860.

The hospital must report recipient inpatient days of other state's Medicaid programs for the period of the audited cost report. For this, the hospital must submit auditable data acceptable to the Department by the April 30th prior to the annual rate update. This due date may be extended by the Department's notice to all Wisconsin hospitals.

Base Data For Major Border Status Hospitals. For major border status hospitals, the number of inpatient days shall be from the hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. The Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. Inpatient days of WMAP recipient stays will come from Department payment records. Cost reporting requirements are described in §4022. For cost reports to be used for combining hospitals, see §5860.

5184 Low-Income Utilization Method.

A hospital with a low-income utilization rate exceeding 25% may also qualify for a disproportionate share adjustment. A hospital has to specifically request the Department to be considered under this method for a disproportionate share adjustment. However, if a hospital qualifies for an adjustment under the Medicaid utilization method but requests an adjustment under the low-income method, the resulting lower adjustment percentage will be used. (See section 5246)

A hospital's "low income utilization rate" would be the sum of the following two percentages (next page), calculated as described on the next page. The Department will designate the cost reporting period.

First Percentage. Total payments from Medicaid to the hospital and total county general assistance program payments to the hospital for inpatient and outpatient services plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient and outpatient services (including the amount of such cash subsidies) in the same cost reporting period. Revenues shall be net revenues after deducting bad debts, contractual allowances and discounts, that is, reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross. Revenues shall also exclude recorded charges for charity care.

Second Percentage. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in a cost reporting period, less the portion of any cash subsidies described above in the period reasonably attributable to inpatient hospital services in the same period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period.

Charity Care. Charity care means health care a hospital provides to a patient who, after an investigation of the circumstances surrounding the patient's ability to pay, including nonqualification for a public program, is determined by the hospital to be unable to pay all or a portion of the hospital's normal billed charges. Charity care does not include any of the following: (1) care provided to patients for which a public program or public or private grant funds pay for any of the charges for the care; (2) contractual adjustments in the provision of health care services below normal billed charges; (3) differences between a hospital's charges and payments received for health care services provided to the hospital's employees, to public employees or to prisoners; (4) hospital charges associated with health care services for which a hospital reduces normal billed charges as a courtesy; or (5) bad debts. Bad debts means claims arising from rendering patient care services that the hospital, using a sound credit and collection policy, determines are uncollectible, but does not include charity care.

Adjustment Factors. The following table lists the disproportionate share adjustment factor for each threshold percentage of the low-income utilization method.

Low-Income Utilization Rate	*Adjustment Percentage*
25.0% through 43.99%	3.0%
44.0% through 62.99%	3.5%
63.0% through 81.99%	4.0%
82.0% & greater	4.5%

The Department has determined that a total of $100,000 (for all hospitals combined) will be available for the DSH rate-based hospital adjustment in FY 2008 and years thereafter. The adjustment percentage to the hospital specific DRG base rate shall be proportionately reduced to comply with this DSH rate-based hospital budget. For example, if all DSH rate-based adjustments must be reduced by 10% to comply with the $100,000 limit, a 5% rate add-on will be reduced to a 4.5% rate add-on. This reduction to the rate add-on may result in rate adjustments that are less than 3%.

The hospital has to provide auditable data acceptable to the Department which is necessary to calculate the above two percentages. For annual DRG rate updates effective on and after July 1, 1992, a hospital must submit auditable data acceptable to the Department by the end of the second month prior to the effective date of the annual rate update. (For example, for a July 1, 1995 rate update, the due date is April 30, 1995.) Data received after the due date may be excluded from determination of the disproportionate share adjustment.

5185 Which Method Allowed.

A hospital will only be allowed an adjustment either under the Medicaid utilization method of §5243 or under the low-income utilization method of §5244. If the Department determines a hospital qualifies for a disproportionate share adjustment under the Medicaid utilization method but the hospital requests an adjustment under the low-income method, the method which provides the lower disproportionate share adjustment percentage shall be used.

5186 Public Notice.

A listing of hospitals qualifying for an adjustment and the amount of the adjustment will be published in the Wisconsin Administrative Register.

5190 Rates for New Acute Care Hospitals

The Department will establish payment rates for new Acute care hospitals under a method other than that described above until cost reports are available for application of the above methodology.

5191 New Acute Care Hospital and Start-Up Period

The start-up period for a new acute care hospital begins the date the hospital admits its first WMAP recipient. The start-up period ends when a full fiscal year Medicare audited cost report is available to the Department at time of rate calculation.

5192 Rates for Start-Up Period

New acute care hospitals are paid a statewide average "cost based DRG payment rate adjusted by case mix" as described in section 5160. Medicare and Medicaid cost principles are used to calculate the statewide average base DRG payment rate. New Hospitals are eligible to receive an "outlier" payment for very high cost cases as described in sections 5321 through 5324. The statewide average cost to charge ratio will be used in determining outlier payments during the start-up period. The statewide average cost to charge ratio will be calculated by summing the total cost of treating Wisconsin Medicaid patients in existing in-state acute care hospitals divided by total Medicaid charges associated with Wisconsin Medicaid patients in the rate year. For details on the cost of Medicaid recipients, see section 5222. New Hospitals are subject to the cost reporting requirements in section 4000.

5200 OUTLIER PAYMENTS UNDER DRG PAYMENT SYSTEM

5210 General

An outlier payment to the hospital provides a measure of relief from the financial burden presented by extremely high cost cases. It is an amount paid on an individual stay in addition to the DRG payment.

Cost based outlier adjustments and length-of-stay based outlier adjustments are provided. Each is described in detail below. If a hospital's claim qualifies under both the cost outlier and the length of stay outlier methods, then the Department shall pay under the method which gives the greater amount to the hospital.

The Department may evaluate the medical necessity of services provided and appropriateness of length of stay for all outlier cases prior to the issuance of outlier payments or, if payment has been made, recoup the same.

5220 Cost Outliers

5221 Qualifying Criteria for a Cost Outlier Payment.

For a hospital's claim to qualify for cost outlier payment, the following criteria apply:

1. The charges for a given case must be usual and customary.
2. The services provided must be medically necessary and the level of care appropriate to the medical needs of the patient.
3. The claim's cost, that is, charges-adjusted-to-cost, must exceed the DRG payment by the amount of the trimpoint applicable to the hospital. The applicable trimpoint will depend on the type and size of the hospital as follows for discharges on and after July 1, 2007.

	----- Trimpoint Amount -----	
Type of Hospital / Bed Size	Less than 100 Beds	100 Beds or Greater
General Medical & Surgical Hospitals	$ 10,000	$ 50,000

4. Hospital stays for which payment is not provided under the DRG payment system do not qualify for outlier payment consideration. This includes, but is not necessarily limited to cases treated at rehabilitation hospitals and IMDs exempt from DRGs, cases treated at hospitals reimbursed on a percent-of-charges basis, and cases for services exempted from DRG payment system under section 7000. Claims for chronic, stable ventilator-dependant hospital patients shall be reimbursed under the ventilator rate and, therefore, are not eligible for a cost outlier payment.

5222 Charges Adjusted-To-Cost.

For Wisconsin Hospitals. For a hospital located in Wisconsin, claim charges are adjusted to costs using the hospital's specific cost-to-charges ratio for WMAP inpatient services. The cost-to-charges ratio to be used will be from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update except the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. For cost reports to be used for combining hospitals, see §5360.

For hospitals for which the Department does not have an audited cost report, the cost-to-charge ratio from the most recent unaudited cost report available to the Department will be used. This unaudited cost-to-charge ratio will be used until the Department gets an audited cost report.

Outlier Payments Continued

If an audited and an unaudited cost report is not available, then the cost-to-charge ratio to be used for the specific hospital will be the average state-wide cost-to-charge ratio which is the ratio of the total state-wide inpatient hospital costs for WMAP services to the total charges for those services. This statewide mean will be used until the Department acquires a cost report from which, if unaudited, the cost-to-charge ratio will be used until the Department gets an audited cost report.

For Major Border Status Hospitals. For a border-status hospital, the Department shall determine a cost-to-charge ratio applicable to inpatient services provided Wisconsin Medicaid recipients by the hospital based on the hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th date precedes the beginning date of the rate year by more than three years, three months. Cost reporting requirements are described in §4022. For cost reports to be used for combining hospitals, see §5360.

If an audited and an unaudited cost report is not available, then the cost-to-charge ratio to be used for the specific hospital will be the average Wisconsin state-wide cost-to-charge ratio which is the ratio of the total Wisconsin state-wide inpatient hospital costs for WMAP services to the total charges for those services. This statewide mean will be used until the Department acquires a cost report from which, if unaudited, the cost-to-charge ratio will be used until the Department gets an audited cost report.

5223 Outlier Payment Calculation.

Variable costs in excess of the DRG payment and the trimpoint will be paid. Following are the steps for calculation of an outlier payment. An example of a cost outlier calculation is presented in appendix section 21000.

1. Allowed claim charges are adjusted to cost by multiplying the charges by the hospital's Medicaid cost-to-charge ratio.

2. The allowed excess claim costs will be calculated by subtracting the case-mix adjusted DRG payment and the hospital's trimpoint from the claim costs. (Claim cost – case-mix adjusted DRG payment - Trimpoint = Excess cost, must be positive to qualify).

3. The outlier payment will be the result of multiplying the excess claim costs by the variable cost factor. The variable cost factors will be:

Type of Hospital	Variable Cost Factor
General Medical & Surgical Hospitals	100%
Major Border Status Hospitals	77%
Non-Border Status and Minor Borders Status Hospitals	77%

5224 Bed Count, Source and Changes.

For rate years beginning on and after July 1, 1992, the trimpoint amount for each hospital shall be established effective July 1 of the rate year based on the bed count on file with the Department's Division of Quality Assurance, as of July 1 of the respective rate year. The hospital may request an administrative adjustment under section 11900, item A, to correct errors by the Department in establishing the appropriate trimpoint.

If a hospital changes its bed count after July 1, any change in the trimpoint amount will not be effective until July 1 of the subsequent rate year. The hospital must provide written notice of its change in bed count to the Division of Quality Assurance in sufficient time that the notice is received by the Division on or before July 1 of the rate year. The hospital should, but is not required to, provide a copy of the notice of the change to the Department's Division of Health Care Financing.

5230 Length of Stay Outliers

5231 Qualifying Criteria.

For a hospital's claim to qualify for length of stay outlier payment, the following criteria apply:

For disproportionate share qualifying hospitals (under section 5180):

1. The hospital qualified for a disproportionate share adjustment at any time during the period of the stay, and
2. The claim is for inpatient services for a child who was under six years of age on date of discharge, and
3. For discharges on and after July 1, 1994, the length of the child's stay exceeds 75 days (threshold days). (Prior to 7/1/94 the threshold was 114 days.)

For all hospitals:

1. The claim is for inpatient services for an infant who was under one year of age on date of discharge, and
2. For discharges on and after July 1, 1994, the length of the infant's stay exceeds 75 days (threshold days). (Prior to 7/1/94 the threshold was 114 days.)

5233 Request for Length of Stay Outlier Payment.

Under administrative adjustment P in §11900, a hospital may request a length of stay outlier payment. The hospital must submit a claim for the stay to the Department's fiscal agent. In addition, the hospital must submit a request for a length of stay outlier payment to the Department with a copy of the claim. The Department will determine if the claim qualifies for an adjustment and will calculate the amount of adjustment.

Hospitals should send requests for a length of stay outlier adjustment to:

Hospitals, Physicians and Clinics Section,
Division of Health Care Financing,
P. O. Box 309,
Madison, WI 53701-0309.

Due Date. The request for this adjustment must be delivered to the Department within 180 days after the date the recipient is discharged from the hospital. This due date applies without regard as to whether or not a claim for the stay has been paid by the Department's fiscal agent.

5234 Calculation of Length-of-Stay Outlier Payment.

The cost will be divided by the length of the stay to determine the cost per day. To calculate variable costs, the cost per day will be multiplied by 77% plus 77% of the disproportionate share percentage. The resulting variable cost per day will be multiplied by the number of days which exceed the threshold days to determine the outlier payment to be made.

If a hospital's claim qualifies under both the cost outlier and the length of stay outlier methods, then the Department shall pay under the method which gives the greater amount to the hospital.

5280 Cost Reports For Recent Hospital Combinings

A “hospital combining” is the result of hospitals combining into one operation, under one WMP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital’s operation or a substantial amount of another hospital’s physical plant. Data from the audited cost reports of each previous (i.e., before the combining) individual hospital will be combined to calculate the following components of the hospital payment rates which require the use of cost report data: the disproportionate share hospital adjustment under section 5180 and the cost-to-charge ratio used for outlier payments under section 5220. When an audited cost report for a full fiscal year of the combined operation becomes available to the Department, that cost report will be used for the subsequent July 1 annual rate update. Under section 11900, item S, the combined or absorbing hospital may request the administrative adjustment to have its payments retroactively adjusted based on its audited cost report when they become available.

5300 OTHER PROVISIONS RELATING TO DRG PAYMENTS

5310 Medically Unnecessary Stays, Defined

Medically unnecessary stays are those stays that are not reasonably expected to improve the patient's condition, that are not for diagnostic study, or that do not require the intensive therapeutic services normally associated with inpatient care. (See EQRO review section below regarding criteria.)

5313 Authority For Recovery

The Department will recover payments previously made or deny payments for medically unnecessary hospital stays and/or inappropriate services based on determinations by the Department, the External Quality Review Organization (EQRO) or other organizations under contract with the Department. The Department is required by federal law to monitor the medical necessity and appropriateness of services provided to WMAP recipients and payments made to providers of such services. Wisconsin statute, section 49.45(3)(f)2m, authorizes the Department to adopt criteria on medical necessity and appropriateness and to deny claims for services failing to meet these criteria.

5316 Review by External Quality Review Organization (EQRO)

The Department contracts with an **External Quality Review Organization (EQRO)** to review selected hospitalizations of WMAP recipients for medical necessity and appropriateness. The process to select those hospitalizations which are reviewed is approved by the Department. The EQRO review criteria are premised on objective clinical signs of patient illness and documentation that intensive hospital services were being provided. The EQRO review process represents a highly professional, clinically sound approach for assuring that hospital services are used only when medically necessary. EQRO criteria is approved by the federal Health Care Financing Administration. The review criteria and periodic updates to it are disseminated to all hospitals in the state.

5319 EQRO Control Number

The hospital must contact the EQRO and acquire a unique case-specific control number from the EQRO for each of the following types of inpatient admissions:

- -- urgent/emergent admissions to hospital IMDs for recipients under 21 years of age,
- -- medical elective admissions, and
- -- admissions for ambulatory/outpatient procedures identified by the Department as needing control numbers.

Payment of inpatient claims for these admissions will be denied if the claims do not include the required case-specific control number from the EQRO.

5323 Inappropriate Inpatient Admission

Payment for inpatient care which could have been performed on an outpatient basis shall not exceed the facility's outpatient rate-per-visit paid under section 4.19B of the Medicaid Hospital State Plan. If payment has been made, the difference between the payment and the outpatient rate-per-visit will be recovered.

5326 Inappropriate Discharge And Readmission

If the EQRO determines that it was medically inappropriate for a patient to have been discharged from a hospital and as a result, that patient needed to be readmitted to a hospital, no payment will be made for the first discharge. If payment has been made, it will be recouped.

5329 Transfers

Patient transfers may be reviewed by the EQRO or the Department for medical necessity. If the transfer is determined to have been medically necessary, then both the transferring and the receiving hospital will be paid the full DRG amount for their discharge.

5336 Days Awaiting Placement

Days awaiting placement are those days of an inpatient hospital stay during which medically necessary services could have been provided to the patient in a nursing facility or some other alternative treatment setting. A DRG weighted discharge payment will not be adjusted for days a WMAP recipient patient awaited placement to an alternative living arrangement. If placement to a NF or an ICF-MR is delayed, not on the hospital's part, for completion of required pre-admission screening for mental illness and/or mental retardation (required under Subtitle C, Part 2 of PL 100-203, the Omnibus Budget Reconciliation Act of 1987), the hospital may request and receive a per diem payment for each allowed day identified as waiting placement due to the lack of the pre-admission screen. This payment shall be in addition to the DRG payment, not to exceed the estimated statewide average NF rate. Each allowed day awaiting placement must be adequately documented for review in the patient chart.

5339 DRG Validation Review

As part of the EQRO review process, the information provided on the hospital claim are verified with the medical record documentation. This review may determine that the DRG initially assigned to the hospital stay was inappropriate. The Department may adjust DRG payment pursuant to the result of EQRO reviews and recover any overpayment which has been made.

5343 IMD Hospital Transfers

An inpatient at an IMD may transfer to an acute care general hospital for a short term stay, then return to the IMD and eventually be discharged from the IMD. If the person's absence from the IMD is due to the person being an inpatient of one or more acute care hospitals for a period of three or less consecutive days, the IMD will not be paid a payment for the transfer to the acute care hospital. If the absence is for a period exceeding three consecutive days, the IMD will receive payment for the transfer to the acute care hospital. Three or less consecutive days means the patient is absent or on-leave from the IMD for three or less successive midnight census counts of the IMD.

The IMD will be eligible for payment for each medically necessary day the patient was included in the census counts of the IMD. The acute care hospital, to which the patient was transferred, will be reimbursed for the medically necessary stay without regard to the patient's length of the stay in the acute care hospital. Any payment to the IMD for a person's inpatient stay is subject to the person being eligible for MA coverage for their stay in the IMD.

5346 Outpatient Services Related To Inpatient Stays

Outpatient hospital claims for services provided to a recipient during an inpatient stay are considered part of the inpatient stay and will be denied. Emergency room services shall be considered part of the inpatient stay, not outpatient services, if the patient was admitted and counted in the midnight census. Outpatient or professional claims on the date of admission or discharge will be allowed if billed by a provider other than the admitting inpatient hospital.

5349 Obstetrical And Newborn Same Day Admission/Discharge

A hospital stay shall be considered an inpatient stay when a WMAP recipient is admitted to a hospital and delivers a baby, even if the mother and the baby are discharged on the date of admission and not included in the midnight census. This consideration applies to both the newborn infant and the mother and also applies in those instances when the recipient and/or newborn is transferred to another hospital.

5353 Changes of Ownership

Payment rates will not change solely as a result of a change of ownership. At the time of ownership change, the new owner will be assigned the hospital-specific DRG base rate of the prior owner. Subsequent changes to the hospital-specific DRG base rate for the new owner will be determined as if no change in ownership had occurred, that is, the prior owner's cost reports will be used until the new owner's cost reports come due for use in the annual rate update.

5356 HMO/PEI Alternative Payment

The Department may establish a reimbursement methodology to pay hospitals directly for the inpatient care of AFDC recipients enrolled in health maintenance organizations in counties where the HMO Preferred Enrollment Initiative (PEI) is mandatory. This reimbursement shall be a prospective DRG, rate-per-discharge or rate-per-diem, depending on the type of hospital, based on MA HMO hospital costs deflated to the base year, adjusted and indexed for the authorized rate increases. The cost of this inpatient care shall be deducted from the HMO capitation rate paid to HMO's.

5360 Cost Report Used For Recent Hospital Combinings

Hospital combinings result from in-state or major border status hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. Data from the audited cost reports of each previous (i.e., before the combining) individual hospital will be combined to calculate the following components of the hospital payment rates which require the use of cost report data: the disproportionate share hospital adjustment under section 5180 and the cost-to-charge ratio used for outlier payments under section 5220 . When an audited cost report for a full fiscal year of the combined operation becomes available to the Department, that cost report will be used for the subsequent July 1 annual rate update. Under section 11900, item S, the combined or absorbing hospital may request the administrative adjustment to have its payments retroactively adjusted based on its audited cost report when they become available.

5362 Provisions Relating to Organ Transplants

Prior Authorization and Criteria. In order for a hospital to receive payment for transplant services, the following criteria must apply:

a. The transplant must be performed at an institution approved by the WMAP for the type of transplant provided. A list of approved hospitals is available from the Division of Health Care Financing, P. O. Box 309, Madison, WI 53701-0309.
b. The transplant must be prior authorized by the Department. Prior authorization requests must be submitted jointly by the hospital and the transplant surgeon, and must include written documentation attesting to the appropriateness of the proposed transplant. Payment will not be made without prior authorization approval.
c. In order to include the acquisition costs in the allowable charges, and not have the "acquisition costs" deducted from the transplant payment rate, the hospital will have to provide assurance to the Department that organs are procured from an organ procurement organization.

Organ Procurement. Organs must be obtained in compliance with the requirements of federal and state statute and regulations.

Transplant Log. Hospitals which perform organ transplants must maintain a log for every organ transplant performed for a WMAP recipient (except bone marrow) indicating the organ procurement organization or agency or source of the organ and all costs associated with procurement. A copy of this log must be submitted along with the transplant hospital's Medicaid cost report, so that the WMAP may document compliance.

5400 Reimbursement for Critical Access Hospitals

Definition: A critical access hospital (CAH) is a hospital that meets the requirements under 42 CFR Part 485, Subpart F and is designated as a critical access hospital by CMS, and is designated as a critical access hospital by the Department.

Critical access hospitals are reimbursed the lower of the hospital's allowable cost or charges for the services provided to Medicaid recipients.

If payments exceed costs, the Department will recover excess payments from the hospital.

If costs exceed interim payments, the Department will reimburse the hospital the amount by which a hospital's costs exceed payments.

The Department will calculate an interim discharge rate based on a hospital's most currently audited cost report. If no cost report is available, the best available data will be used to set an interim rate.

Interim reimbursement may be adjusted to minimize the expected amount of excess payments that will need to be recovered from a CAH or the amount of expected additional payments the Department will need to make to a CAH. A CAH may request an adjustment to its interim payments until a final cost settlement can be calculated. No more than two such adjustment requests will be recognized by the Department for any fiscal year of the hospital. Upon consultation with the Department, the hospital must provide the Department sufficient information so that the interim adjustment is a reasonable and reliable estimate of the final cost settlement. The Department may deny an adjustment that is not significant.

Total inpatient payments may not exceed charges as described in section 9000.

SECTION 6000
HOSPITALS PAID UNDER PER DIEM RATE

6100 COVERED HOSPITALS

Rehabilitation hospitals, state-operated IMD Hospitals, psychiatric hospitals, and state operated veterans' hospitals will be paid under a rate per diem. Services described in section 7000 are exempted from reimbursement under this section if reimbursement is requested by and approved for the hospital according to section 7000.

6200 PAYMENT RATES FOR STATE, PRIVATE AND NON-STATE PUBLIC MENTAL HEALTH INSTITUTES

This section 6200 describes how hospital institutions for mental disease owned and operated by the State and psychiatric hospitals are reimbursed for services provided to Medicaid recipients. Reimbursement for inpatient hospital services will be a final reimbursement settlement for each hospital's fiscal year based on the hospital's allowable cost incurred in its fiscal year. All services provided during an inpatient stay, except professional services described in section 6480, will be considered inpatient hospital services for which payment is provided. Professional services described in section 6480 may be include in the final reimbursement settlement if a waiver or variance is approved under the procedures described in section 6258.

6210 Interim Rate Per Diem for State owned and Operated IMDs

Patient stays in a hospital covered by this section will be paid at interim or temporary rates per diem until a final reimbursement settlement can be completed for the hospital's fiscal year. The interim rate effective in a rate year, July to June, will be based on the interim rate per diem paid on June 30 of the prior rate year excluding any disproportionate share adjustment of section 5180. (The rate paid on the June 30 prior to the effective date of this change in reimbursement methodology will be the base for the interim rate effective on the effective date of this change.) The June 30 rate will be adjusted by an inflation multiplier sourced from the "Health-Care Cost Review Index"published by Global Insight, Inc. The result will be increased by any disproportionate share adjustment for which the hospital may qualify under section 5180. The resulting interim rate will be increased if the hospital justifies an adjustment based on its historical expenses or expected expenses. The Department may at any time decrease the interim rate if it determines federal upper payment limits may be exceeded.

6220 Final Reimbursement Settlement for State owned and Operated IMDs

After a hospital completes each of its fiscal years, a final reimbursement settlement will be completed for Medicaid inpatient services provided during the year. The allowable costs a hospital incurred for providing Medicaid inpatient services during its fiscal year will be determined from the hospital's audited Medicaid cost report for the fiscal year. Allowable costs will include the net direct costs of education activities incurred by the hospital as determined according to 42 CFR δ413.85. Covered education activities include those allowed under δ413.85 and approved residency programs, allowed under 42 CFR δ413.86, in medicine, osteopathy, dentistry and podiatry.

A disproportionate share hospital (DSH) adjustment will be determined according to section 5180 if the hospital meets the qualifying criteria of that section. The DSH adjustment percentage will be applied to the allowable cost of Medicaid inpatient services for the fiscal year to determine the hospital's DSH payment. To calculate the adjustment percentage, the formulae and related fixed variables of section 5180, that were in effect on the July 1 date in the hospital's fiscal year, will be applied to the patient utilization incurred by the hospital in its fiscal year.

The final reimbursement settlement will take the following federal payment limits into consideration:

- Total final reimbursement may not exceed charges according to section 9000.
- Compliance with the federal upper payment limit of 42 CFR δ447.272, also know as the Medicare upper-limit, will be retrospectively determined when the final settlement is determined. If necessary, final reimbursement will be reduced in order that this federal upper payment limit is not exceeded.
- The hospital's disproportionate share payment may not exceed the limits of section 9100 which will be determined based on the hospital's fiscal year cost report used for the final settlement.
- Disproportionate share payment in the final reimbursement will be reduced, if necessary, to not exceed the State's limitations on aggregate payments for disproportionate share hospitals under 42 CFR 447.297.

If the total amount of final reimbursement, including DSH payment, for the hospital's fiscal year exceed the total interim payments for the year, then the difference will be paid to the facility. The difference will be recovered if the total final reimbursement, including DSH payment, is less than the total interim payments.

6220 Final Reimbursement Settlement for State owned and Operated IMDs, continued

The above reimbursement methodology is being implemented effective on a date that might not be the beginning date of a covered hospital's fiscal year. That is, the first months of such a hospital's fiscal year will not be covered, while the latter months are covered by the cost settlement. In such a case, the hospital's Medicaid allowable cost for its full fiscal year will be prorated between the months not covered and months covered by this reimbursement methodology based on the number f Medicaid inpatient days in each period.

6230 Calculation of Per Diem Rates for All Other Psychiatric IMDs

Patient stays in a hospital covered by this section will be paid at a prospective per diem cost based rate. The prospective per diem rate will be based on the most recently available audited Medicare cost report. A cost per day will be calculated for routine inpatient services using Medicare and Medicaid cost principles. Medicaid ancillary costs will be apportioned by deriving cost to charge ratios for each ancillary service. The total ancillary Medicaid costs will be divided by total paid Medicaid days from the Medicaid Management Information System (MMIS) to calculate an ancillary Medicaid cost per day. The routine plus the ancillary cost per day will serve as the Medicaid prospective payment rate. The Medicaid cost per diem will be adjusted by the disproportionate share adjustment factor if applicable. The disproportionate share adjustment factor will be determined pursuant to section 5180. Payment rates will be updated on an annual basis. Final hospital-specific per diem payment rates are based on provider costs but are subject to a reduction factor to ensure compliance with the Department's annual budget.

6240 Rates for New All Other Psychiatric IMDs

The Department will establish payment rates for new psychiatric hospitals under a method other than that described above until cost reports are available for application of the above methodology.

6250 New All Other Psychiatric IMDs and Start-Up Period

The start-up period for a new psychiatric hospital begins the date the hospital admits its first WMAP recipient. The start-up period ends when a full fiscal year Medicare audited cost report is available to the Department at time of rate calculation.

6260 Rates for Start-Up Period

The per diem rates to be paid during the start-up period shall be an average of the rates being paid to other psychiatric hospitals in the state, not including rates being paid to new psychiatric hospitals during a start-up period. The start-up rate being paid to a new psychiatric hospital will be adjusted prospectively based on the recalculated statewide average rate without a retroactive payment adjustment.

In calculating the statewide average rate, any disproportionate share adjustments which are provided to the other psychiatric hospitals will not be included. The new hospital may request an 'administrative adjustment action' for disproportionate share adjustments to be applied to its start-up rates. Section 6270 below describes the criteria for the administrative adjustment action.

6270 Administrative Adjustment Criteria for Disproportionate Share Adjustment for New Hospital

A new psychiatric hospital may request a disproportionate share (DSH) adjustment under administrative adjustment item R in section 11900. For its rates during the start-up period and the first rate year after the start-up period, this administrative adjustment allows DSH adjustments to be based on Medicaid inpatient day utilization for periods other than that specified in §5223.

6300 CALCULATION METHODOLOGY FOR REHABILITATION HOSPITALS

Section 6310 applies to established rehabilitation hospitals which are not considered new. Section 6320 applies to new rehabilitation hospitals for the period described in that section.

6310 Calculation of Per Diem Rates for Established Rehabilitation Hospitals

Patient stays in a hospital covered by this section will be paid at a prospective per diem cost based rate. The prospective per diem rate will be based on the most recently available audited Medicare cost report. A cost per day will be calculated for routine inpatient services using Medicare and Medicaid cost principles. Medicaid ancillary costs will be apportioned by deriving cost to charge ratios for each ancillary service. The total ancillary Medicaid costs will be divided by total paid Medicaid days from the Medicaid Management Information System (MMIS) to calculate an ancillary Medicaid cost per day. The routine plus the ancillary cost per day will serve as the Medicaid prospective per diem payment rate. The Medicaid cost per diem will be adjusted by the disproportionate share adjustment factor if applicable. The disproportionate share adjustment factor will be determined pursuant to section 5180. Payment rates will be updated on an annual basis. Final hospital-specific per diem payment rates are based on provider costs but are subject to a reduction factor to ensure compliance with the Department's annual budget.

6320 Rates for New Rehabilitation Hospitals

The Department will establish payment rates for new rehabilitation hospitals under a method other than that described above until cost reports are available for application of the above methodology.

6322 New Rehabilitation Hospital and Start-Up Period

The start-up period for a new rehabilitation hospital begins the date the hospital admits its first WMAP recipient. The start-up period ends the June 30th date following completion of the hospitals fourth full (12 month) fiscal year after the fiscal year in which the first WMAP recipient was admitted. (For example, a hospital's fiscal year ends each September. It admitted its firs WMAP recipient on March 10, 1994. Its fourth full fiscal year after the admission ends September 30, 1998. The next rate year begins July 1, 1999. Therefore, the hospitals start-up period is March 10, 1994 through June 30, 1999.)

6324 Rates for Start-Up Period

The rates per diem to be paid during the start-up period shall be an average of the rates being paid to other rehabilitation hospitals in the state, not including rates being paid new rehabilitation hospitals during a start-up period. If a rate being paid to a rehabilitation hospital is adjusted as is called for in step 1 of §6310, the statewide average rate will be recalculated. The start-up rate being paid to a new rehabilitation hospital will be adjusted prospectively based on the recalculated statewide average rate without a retroactive payment adjustment.

In calculating the statewide average rate, any disproportionate share adjustments which are provided to the other rehabilitation hospitals will not be included. The new hospital may request an 'administrative adjustment action' for disproportionate share adjustments to be applied to its start-up rates. Section 6328 below describes the criteria for the administrative adjustment action.

6326 Rates After Start-Up Period Ends

Rates will be established according to the methodology described in §6310 above after the start-up period ends. Two base cost reporting periods, not three as called for in step 1 of §6310, will be used for establishing rates for the initial rate year after the start-up period. (A rate year is July 1 to June 30.) For the subsequent rate years, three base cost reporting periods will be used as is specified in §6310.

6328 Administrative Adjustment Criteria for Disproportionate Share Adjustment for New Hospital

A new rehabilitation hospital may request a disproportionate share (DSH) adjustment under administrative adjustment item R in section 11900. For its rates during the start-up period and the first rate year after the start-up period, this administrative adjustment allows DSH adjustments to be based on Medicaid inpatient day utilization for periods other than that specified in section 5180.

6400 OTHER PROVISIONS RELATING TO PER DIEM RATE SYSTEM

6410 Medically Unnecessary Days, Defined (Under Per Diem Rate System)
Medically unnecessary days are those days that are not reasonably expected to improve the patient's condition, that are not for diagnostic study, or that do not require the intensive therapeutic services normally associated with inpatient care. (See EQRO review section below regarding criteria.)

6413 Authority For Recovery (Under Per Diem Rate System)
The Department will recover payments previously made or deny payments for medically unnecessary hospital stays or days and/or inappropriate services based on determinations by the Department, the Wisconsin Peer Review Organization (EQRO) or other organizations under contract with the Department. The Department is required by federal law to monitor the medical necessity and appropriateness of services provided to WMAP recipients and payments made to providers of such services. Wisconsin statute, section 49.45(3)(f)2m, authorizes the Department to adopt criteria on medical necessity and appropriateness and to deny claims for services failing to meet these criteria.

6414 Calculation Of Recoupment (Under Per Diem Rate System)
The amount to be recouped for medically unnecessary stays or days is calculated by multiplying the rate per diem times the number of denied days, less any co-payment or third-party payment

6416 Review by Wisconsin Professional Review Organization (EQRO). Section 5316 applies to hospitals under the per diem rate system.

6419 EQRO Control Numbers. Section 5319 applies to hospitals under the per diem rate system.

6423 Inappropriate Inpatient Admission. Section 5323 applies to hospitals having per diem rates.

6436 Days Awaiting Placement (Under Per Diem Rate System)
Days awaiting placement are those days of an inpatient hospital stay during which medically necessary services could have been provided to the patient in a nursing facility or some other alternative treatment setting. Payment under the prospective rate-per-diem will be adjusted for days a WMAP recipient patient is awaiting placement to an alternative living arrangement. For those days identified as awaiting placement, payment shall be adjusted to an amount not to exceed the statewide average skilled care per diem rate for nursing facilities (NFs). Each allowed day awaiting placement shall be documented through patient chart review and subject to criteria established by the WMAP. The amount to be recouped is calculated by subtracting the skilled care rate from the rate per diem and multiplying by the days awaiting placement. The amount to be recouped is also reduced by the applicable amount of co-pay and third-party liability (TPL) payments.

6443 Temporary Hospital Transfers (Under Per Diem Rate System)
When an inpatient in a hospital paid under the prospective rate per diem system is transferred to an acute care general hospital and transferred back, no per diem payment shall be provided to the hospital for the days of absence. The acute care hospital, to which the patient temporarily transferred, will be reimbursed by the WMAP for the medically necessary stay.

6446 Outpatient Services Related to Inpatient Stay. Section 5346 applies to hospitals under the per diem rate system.

6453 Changes of Ownership. Section 5353 applies to hospitals under the per diem rate system.

6456 HMO/PEI Alternative Payment. Section 5356 applies to hospitals under the per diem rate system.

6460 Cost Report Used For for Recent Hospital Combinings (Under Per Diem Rate System)

Hospital combinings result from in-state or major border status hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. Data from the audited cost reports of each previous individual hospital will be combined to calculate any per diem rate which requires the use of audited cost reports. When an audited cost report for a full fiscal year of the combined operation becomes available to the Department, that cost report will be used in the subsequent July 1 annual rate update. Under section 11900, item S, the combined or absorbing hospital may request the administrative adjustment to have its payments retroactively adjusted based on its audited cost report when they become available.

6470 SERVICES COVERED BY PER DIEM RATE PAYMENTS UNDER SECTION 6000

All covered services provided during an inpatient stay, except professional services described in §6480, shall be considered hospital inpatient services for which per diem payment is provided under this section 6000. (Reference: Wis. Admin. Code, HFS 107.08(3) and (4))

6480 PROFESSIONAL SERVICES EXCLUDED FROM PER DIEM RATE PAYMENTS UNDER SECTION 6000

Certain professional and other services are not covered by the per diem payment rates under this section 6000. To be reimbursed by the Wisconsin Medicaid program, professional services must be billed by a separately certified provider and billed on a claim form other than the UB-92 hospital claim form. The following services are excluded from the per diem payment rates and may be billed separately when the professionals are functioning in a capacity listed below.

Physicians	Optometrists	Pharmacy, for take home drugs on the date of discharge
Psychiatrists	Hearing aid dealers	
Psychologists	Audiologists	Durable medical equipment and supplies for non-hospital use
Physician assistants	Podiatrists	
Nurse midwives	Independent nurse practitioners	Specialized medical vehicle transportation
Chiropractors	Anesthesia assistants	
Dentists	Certified registered nurse anesthetists	Air, water and land ambulance

SECTION 7000
SERVICES EXEMPTED FROM THE DRG PAYMENT SYSTEM

7100 PAYMENT FOR ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

7110 AIDS Acute Care and AIDS Extended Care Rates of Payment. (Rates listed in §7900)

The current payment rates per diem for AIDS acute care and for AIDS extended care are listed in section 7900. These per diem rates apply for instate hospitals, major and minor border-status hospitals and non-border status hospitals.

Total payment is calculated as the sum of the acute care per diem times the number of approved acute care days plus the extended care per diem times the number of approved extended care days. Payment will not exceed total covered charges.

7150 Patient Criteria For Approval To Receive AIDS Rate of Payment

7150.2 Acute Care. Payment of the acute care rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP. The request is to be submitted through the WMAP prior authorization (PA) process. The following criteria apply:

a. The patient must have an established diagnosis of AIDS.
b. Clinical findings and other relevant medical information must substantiate the medical necessity and appropriateness of the hospitalization and its payment at the AIDS acute care rate.
c. Medical record documentation supporting the medical necessity and appropriateness of acute inpatient care must be submitted with the request for approval.

Approval for the acute care per diem is granted for a specified period of time. If the patient still meets the intensity and severity criteria for acute care, the provider must submit a subsequent request for extension of the payment approval.

7150.3 Extended Care. Payment of the extended care rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP. The request is to be submitted through the WMAP prior authorization (PA) process. The following criteria must be met:

a. The patient must have an established diagnosis of AIDS.
b. The patient must be medically stable per discharge indicators appropriate for the system involved.
c. The patient must require infection control procedures and isolation techniques.
d. Reasonable attempts at securing alternative living situations that allow for correct infection control procedures and isolation techniques must have been unsuccessful and an appropriate plan of care and discharge plan must have been established.
e. The degree of debilitation and amount of care required must equal or exceed the level of skilled nursing care provided in a nursing facility (NF).
f. Sufficient documentation supporting these criteria must be submitted with the request for approval.

Approval for the extended care rate is granted for a specified period of time, after which if the patient still meets the intensity and severity criteria for extended care, the provider must submit a subsequent request for extension of the payment approval.

The progression of illness may require acute care services during the period established for extended care. Therefore, during an "extended care" period, the acute care payment rate will be approved for payment after the hospital has provided an acute level of care for at least five days and the WMAP determines the above acute care criteria are met.

7160 No Outlier Payment and Administrative Adjustment.

AIDS cases paid under the per diem rate of this section do not qualify for outlier payments. AIDS reimbursement rates are not subject to administrative adjustment.

7170 If AIDS Exemption Discontinued

In the event that the AIDS payment rate is discontinued, the Department is obligated to pay for services at the latest rate adjusted annually for inflation until alternative placement for these patients can be found. The hospital will provide care to these patients at this latest rate until such time that an alternative placement can be found.

7200 PAYMENT FOR VENTILATOR-ASSISTED PATIENTS

7210 Rate of Payment (Rates listed in §7900)

The per diem payment rate for long-term ventilator services is listed in section 7900. Hospitals are required to bill on a monthly basis. This rate applies to instate hospitals, major and minor border-status hospitals and non-border status hospitals.

7250 Criteria For Approval To Receive Ventilator-Assistance Payment Rate

7250.2 Patient Criteria. Payment of the ventilator-assistance rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP based on the following criteria. The request is to be submitted through the WMAP prior authorization (PA) process. If one or more of the following criteria are not met, payment of the ventilator-assistance rate may be approved by the WMAP if it is determined that payment of such rate to the hospital for the patient's stay is expected to be less costly than alternative ventilator assistance services.

a. The patient must have been hospitalized continuously in one or more hospitals for at least thirty consecutive days;
b. The ventilator-assisted patient must be in a medically stable condition requiring an inpatient level of care;
c. Attempts at weaning the patient from the ventilator are inappropriate or must have failed;
d. The ventilator-assisted patient must require ventilator assistance six or more hours per day;
e. Home care must be an unacceptable alternative because of financial/economic hardship or because of the lack of adequate support system; and
f. Nursing home placement must be inappropriate because of the high level or type of care required or non-availability.

7250.3 Dedicated Unit Provisions. If a hospital has a specialized nursing unit dedicated to the care of ventilator-assisted patients, the Department will allow the hospital to be reimbursed retroactive to the first day of the stay in the dedicated unit even if that date is prior to the date of approval for payment at the ventilator-assistance rate.

7250.4 Transfers. Hospitals will continue to be paid the ventilator rate when ventilator-assisted patients are transferred to acute care or intensive care units for complications associated with their ventilator dependency. Hospitals will be paid the prospective DRG rate for transfers and/or admissions to acute care settings for medical problems unrelated to their ventilator dependency, provided the acute care stay lasts more than five days.

7260 No Outlier Payment and Administrative Adjustment.

Claims for patients who are eligible for this exceptional payment rate cannot be reimbursed as outliers. The ventilator-assistance reimbursement rates is not subject to administrative adjustment.

7270 Ventilator-Assistance Exemption Discontinued.

In the event that the Department discontinues the ventilator-assisted payment rate, the Department is obligated to pay for services at the most current rate adjusted annually for inflation until such time as an alternate placement for patients is found. The hospital will continue to provide care to these patients at this rate until alternative placement is found.

7400 NEGOTIATED PAYMENTS FOR UNUSUAL CASES

Notwithstanding other reimbursement provisions of this plan, the Department may allow an alternative payment for non-experimental inpatient hospital services if the WMAP determines that all of the following requirements are met:

1. The services are either:
    a. Necessary to prevent death of a recipient or
    b. Life threatening impairment of the health of a recipient or
    c. Grave and long lasting physical health impairment of a recipient or
    b. Cost effective compared to an alternative service or alternative services.
2. At the time this plan was submitted, the service(s) as proposed:
    a. Was not reasonably accessible for WMAP recipients; or
    b. Had not been a WMAP approved service provided for the particular purpose(s) intended; or
    c. Had not been a WMAP approved service provided under similar medical circumstances; or
    d. Required performance in the hospital which, given the circumstances of the recipient's case, is the only feasible provider or one of the only feasible providers known to the WMAP.
3. Existing payment methods are inadequate to ensure access to the services proposed for the recipient.
4. All applicable prior authorization requirements are met.

This §7400 applies to in-state hospitals, major and minor border status hospitals, and out-of-state hospitals not having border status.
Alternative payments made under this provision shall be set on a case by case basis and shall not exceed the hospital's charges.

Requests for alternative payments under this provision are to be made to the: Office of the Administrator, Division of Health Care Financing, 1 West Wilson Street, Suite 350, P.O. Box 309, Madison WI 53701-0309 (telephone 608-266-2522 or FAX 608-266-1096).

Requests must be submitted prior to admission, during the hospital stay or not later than 180 days after the WMAP recipient's discharge from the requesting hospital in order for an alternative payment to apply, at the discretion of the WMAP, beginning with the admission date (if applicable prior authorization requirements have been met to allow retroactive payment).

7500 BRAIN INJURY CARE

7520 In-State and Border-Status Hospitals. A rate per diem is provided for prior authorized care of MA recipients in a hospital's brain injury care program which has been approved by the WMAP. The hospital's brain injury care program must be approved by the WMAP and each recipient's participation in the program must be prior authorized by the WMAP. The criteria for approval of a program and for prior authorization of an MA recipient's participation in the program is available from the Division of Health Care Financing (see address, section 100, page 1).

Periodic payment will be made to the hospital at the applicable rate per diem specified below. After completion of the hospital's fiscal year, total payments at the rates per diem in effect for brain injury care of prior authorized MA recipient services during its fiscal year will be determined. These total payments will be compared to the hospital's charges for the services and to the hospital's audited cost of providing the services. If the total payments exceed the total charges or the total costs, whichever is lesser, then the excess amount of payments will be recovered from the hospital.

The rates per diem for brain injury care programs for in-state and major and minor border status-hospitals are listed in section 7900. The WMAP may determine and approve additional rates for brain-injury care programs which provide significantly different services than are provided in the types of programs listed in section 7900.

7540 Non-Border Status Hospitals.
Out-of-state non-border status hospitals will be paid at 68% of charges for prior authorized stays for brain injury care.

7900 PAYMENT RATES FOR SERVICES EXEMPTED FROM DRG PAYMENT SYSTEM

These payment rates are established by applying the general payment rate increase provided by the state's biennial budget to the rate in effect for the prior rate year.

For Section	Services	Rate Per Diem Effective July 1, 1996	Effective July 1, 1997	Effective July 1, 1998
7100	AIDS Acute Care.....	$ 570	$ 582	$ 597
7100	AIDS Extended Care.....	$ 314	$ 321	$ 329
7200	Long-Term Ventilator Services.....	$ 444	$ 453	$ 465
7500	Brain Injury Care			
	Neurobehavioral Program Care.....	$ 780	$ 796	$ 816
	Coma-Recovery Program Care.....	$ 937	$ 957	$ 981

7990 SERVICES COVERED BY PAYMENT RATES IN SECTION 7900 ABOVE

All covered services provided during an inpatient stay, except professional services described in §7992, are considered hospital inpatient services for which payment is provided under the payment rates listed in section 7910 above. (Reference: Wis. Admin. Code, HFS 107.08(3) and (4))

7992 PROFESSIONAL SERVICES EXCLUDED FROM PAYMENT RATES IN SECTION 7910 ABOVE

Certain professional and other services are not covered by the payment rates listed in section 7910 above. To be reimbursed by the Wisconsin Medicaid program, professional services must be billed by a separately certified provider and billed on a claim form other than the UB-92 hospital claim form. The following services are excluded from the above payment rates and may be billed seperately when the professionals are functioning in a capacity listed below.

Physicians	Optometrists	Pharmacy, for take home drugs on the date of discharge
Psychiatrists	Hearing aid dealers	
Psychologists	Audiologists	Durable medical equipment and supplies for non-hospital use
Physician assistants	Podiatrists	
Nurse midwives	Independent nurse practitioners	Specialized medical vehicle transportation
Chiropractors	Anesthesia assistants	
Dentists	Certified registered nurse anesthetists	Air, water and land ambulance

SECTION 8000
FUNDING OF INPATIENT MEDICAID DEFICIT IN GOVERNMENTAL HOSPITALS

8001 GENERAL INTRODUCTION

This is referred to as deficit reduction funding and is an adjustment to prior year costs as defined in 45 CFR §95.4. This reimbursement is available for hospital fiscal years beginning on and after July 1, 2006 and is determined based on a hospital's cost report for its completed fiscal year.

8010 QUALIFYING CRITERIA

A hospital will qualify for deficit reduction funding if:

(a) The hospital is an acute care general hospital operated by the State or a local government in Wisconsin.

(b) It incurred a deficit from providing Medicaid inpatient services (described in §8020 below),

(c) The governmental unit that operates the hospital certifies it has expended public funds to fund the deficit.

8020 DEFICIT FROM PROVIDING MEDICAID INPATIENT SERVICES

The deficit from providing inpatient services to Wisconsin Medicaid recipients, that is, the Medicaid deficit, is the amount by which cost exceeds the payment for the Medicaid inpatient hospital services. The cost of Medicaid inpatient services is identified from the hospital's audited cost report for the hospital's fiscal year under consideration for the deficit reduction. Payment above refers to the total of the reimbursement provided under the provisions of section 5000 and sections 8200 to 8500 of this Attachment 4.19A of the State Plan for inpatient services for the respective fiscal year.

8025 INTERIM PAYMENT, INTERIM RECONCILIATION, AND THE FINAL RECONCILIATION

Wisconsin will identify the total amount of uncompensated Medicaid Fee-For-Service Inpatient (FFS) hospital costs as described in Section 8020 to determine interim Medicaid payments under this section until finalized hospital cost reports are available. For the payment year, the per diem costs for routine cost centers and cost to charge ratios for ancillary cost centers are determined using the hospital's most recently filed Medicare cost report (CMS 2552), as filed with the Medicare Fiscal intermediary. The process for the Interim Medicaid Payment Calculation is as follows:

The following process is used to determine inpatient hospital costs:

Step 1

Total hospital costs are identified from Worksheet B Part I Column 27, line 25 through 58.02. Total hospital patient days for inpatient routine costs are identified from Worksheet S-3 Part I Column 6.

Step 2

The cost and total hospital patient days from Step 1 represent the total hospital costs and days for purposes of determining the cost to charge ratios for ancillary cost centers and a calculated per diem cost for routine cost centers.

Step 3

The hospital's total charges by cost center are identified from Worksheet C Part I Column 8.

8025 INTERIM PAYMENT, INTERIM RECONCILIATION, AND FINAL RECONCILIATION, cont.

Step 4

The total hospital charges are included on Worksheet C Part I Column 8 lines 25 through 58.02. Organ acquisition costs for organs transplanted to Medicaid recipients will be calculated by applying Worksheet D-6 cost data from the CMS 2552 form.

Step 5
The state will calculate a per diem for each routine cost center. For each inpatient routine cost center a per diem cost is calculated by dividing total hospital costs from Step 1, Worksheet B Part I Column 27, line 25 through 26.06, divided by total days identified in Step 1 Worksheet S-3 Part I Column 6, line 12 multiplied by Medicaid hospital FFS days identified from MMIS records for the most recent completed state fiscal year ending June 30. Long term care cost centers are excluded from this process. The A&P routine per diem, in accordance with CMS-2552 worksheet D-1, is computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The state will calculate a cost to charge ratio for each ancillary cost center. For ancillary cost centers, a cost to charge ratio is calculated by dividing the total hospital costs from Step 2 by the total hospital charges from Step 4.

The hospital cost to charge ratios and per diem allocation determined through the above process (steps 1-5) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid FFS for the payment year are determined as follows:

Step 6

To determine the inpatient hospital routine and ancillary cost center costs for the payment year, the hospital's projected Medicaid FFS inpatient charges by cost center are used. To project Medicaid hospital FFS charges as accurately as possible for the payment year, the projection will be based upon the hospital's actual experience of Medicaid FFS inpatient charges for the most recent 6-month period. The projected charges are multiplied by the CMS Hospital Market Basket inflation rate published by DRI. The projected charges are then multiplied by the cost to charge ratios from Step 5 for each respective ancillary cost center and the per diem cost is multiplied by the Medicaid hospital FFS inpatient days to determine the Medicaid FFS inpatient costs for each routine service cost center.

Step 7

The Medicaid hospital FFS costs eligible to be reimbursed under this section are determined by adding the Medicaid FFS inpatient costs from Step 6, and subtracting estimated Medicaid FFS inpatient payments. The payment estimate will be based on the hospital's Medicaid FFS payment experience for the most recent 6-month period.

Interim Reconciliation

The hospital costs determined through the methods described for the payment year are reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary. For purposes of this reconciliation, the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 5

Hospital costs and charges and patient days from the as-filed CMS 2552 cost report are used.

Step 6

Medicaid hospital FFS charges and inpatient days from MMIS paid claims data are used subject to provider reconciliation.

8025 INTERIM PAYMENT, INTERIM RECONCILIATION, AND THE FINAL RECONCILIATION, continued

Step 7

Medicaid hospital FFS payments subject to provider reconciliation are used.

Final Reconciliation
Once the CMS 2552 cost report for the payment year has been finalized by the Medicare fiscal intermediary, reconciliation of the finalized amounts will be completed, including use of the Worksheet D apportionment process. In the final reconciliation, Medicaid FFS cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series including 1) computing a per diem for each routine cost center and applying the applicable Medicaid inpatient days from MMIS records for the completed state fiscal year ending June 30 to the per diem amount; 2) using the appropriate Worksheet D-1 lines to compute the per diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and 3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid hospital charges for each ancillary cost center. Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly excepted for Medicaid.

8030 LIMITATIONS ON THE AMOUNT OF DEFICIT REDUCTION FUNDING

The combined total of: (a) the deficit reduction funding, and (b) all other payments to the hospital for inpatient Medicaid services, will not exceed the hospital's total charges for the services for the settlement year. If necessary, the deficit reduction funding will be adjusted so the combined total payments do not exceed charges.

The aggregate deficit reduction funding provided hospitals under this section will not exceed the amount for which FFP is available under federal upper-payment limits at 42 CFR 447.272.

There can be no Medicaid fee-for-service deficit for inpatient hospital services used to calculate any Disproportionate Share Hospital (DSH) payment.

8035 PAYMENT IN EXCESS OF COST

If hospital payments exceed hospital costs, the financial gain from MA payments or payments for the uninsured will be applied against the unrecovered cost of uninsured patients/MA shortfall.

8040 HOSPITAL MUST REQUEST FUNDING

A hospital must apply to the Department for deficit funding under this section 8000. The request must specify the fiscal year for which the hospital has requested deficit funding. The Department will determine if a hospital qualifies for deficit funding.

SECTION 8200
SUPPLEMENTAL DISPROPORITONATE SHARE HOSPITAL PAYMENTS FOR ESSENTIAL ACCESS CITY HOSPITALS (EACH)

The special payments described in this section 8200, specifically subsections 8210 through 8230, are disproportionate share hospital payments provided in accord with the federal Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923.

Supplemental disproportionate share hospital payments are provided for any hospital located in Wisconsin which meets the following criteria for an "essential access city hospital" (EACH).

8210 Qualifying Criteria for EACH Disproportionate Share Hospital Supplement

A hospital qualifies for an EACH supplement in the current rate year if in the current rate year the hospital qualifies for a disproportionate share hospital adjustment under section 8200 and if the hospital met the following criteria during the year July 1, 1995 through June 30, 1996.

1) The hospital is located in the inner city of a city of the first class in Wisconsin as identified by the following U.S. Postal Service Zip Code areas. As of July 1, 1997, the following contiguous U.S. Postal Service Zip Code areas identify one inner city area covered by this supplement: 53202, 53203, 53205, 53206, 53208, 53209, 53210, 53212, 53216 and 53233.
2) At least 30% of the hospital's Medicaid recipient inpatient stays are for Medicaid recipients who reside in an inner city zip code area listed above.
3) More than 30% of the hospital's total inpatient days are Medicaid covered inpatient days.
    (a) including Medicaid HMO covered days and Medicaid covered stays on which Medicaid made no payment due to the stay being covered by some other payer such as hospitalization insurance
    (b) but not including days of Medicaid recipients' stays that are covered in full or part by Medicare.
4) The hospital is an acute care general hospital providing medical and surgical, neonatal ICU, emergency and obstetrical services.

8215 Determination of EACH Disproportionate Share Hospital Supplement

The EACH supplement is paid in a prospectively established monthly amount based on the past Medicaid utilization of the hospital. The amount of a qualifying hospital's supplement is recalculated annually for the upcoming rate year. The total statewide funding for the EACH supplement is limited to the amount that is listed in Appendix Section 22000. This amount is distributed proportionately among qualifying hospitals based on Medicaid inpatient days of the qualifying hospitals.

A qualifying hospital's EACH supplement will be determined as follows:

$$\text{Hospital's Annual EACH Supplement} = \frac{\text{Medicaid days for hospital}}{\text{Sum of Medicaid days of qualifying hospitals}} \times \text{Statewide Annual Funding Listed in Appendix 27100}$$

The monthly amount is the above annual amount divided by 12 months.

Medicaid days are a hospital's total covered inpatient days for Medicaid recipients for the calendar year prior to the rate year for which the EACH supplement is being calculated. The days include Medicaid HMO covered days and Medicaid covered days on which Medicaid made no payment due to the days being covered by some other payer such as hospitalization insurance but do not include days of Medicaid recipient stays that are covered in full or part by Medicare.

Sanction on Not Continuing To Meet Qualifying Criteria

A hospital receiving an EACH supplement is expected to maintain its effort to serve MA recipients including recipients and residents in the inner city area. If the Department finds a hospital fails to meet the above qualifying criteria above for any three month period, then payment of the supplement will be discontinued for the hospital and payments made for the three month period will be recovered. If the hospital shows it subsequently meets the criteria for any three-month period, then the supplemental payment will be reinstated at, and retroactive payment made since, the beginning of the three-month period in which the criteria were again met. If any qualifying hospital is sanctioned in a rate year, the monthly supplement of other qualify hospitals will not be recalculated to redistribute the total annual funding for the EACH supplement.

SECTION 8300
GENERAL ASSISTANCE DISPROPORTIONATE SHARE HOSPITAL ALLOWANCE

This is a separate DSH allotment for areas covered by an Indigent Care Agreement (ICA) for indigent care approved by the single state agency. The areas covered by an ICA must be within reasonable geographic proximity to the hospital receiving the ICA DSH payment. The ICA must be between the hospital and a general assistance medical program in the area. The ICA must stipulate that direct or indirect health care services be provided to low-income patients with special needs who are not covered under other public or private health care programs. No payment will be made under this section to any hospital with a contractual obligation to forward that payment to any entity.

To be eligible for DSH payments made under this section, hospitals must meet minimum federal requirements for Medicaid DSH payments and have an approved ICA in place.

8305 Introduction.
If above ICA provisions are met, qualifying acute care hospitals located in major urban counties will receive a disproportionate share hospital (DSH) payment for providing a significant amount of services to low-income persons residing in those counties who are not eligible for Wisconsin Medicaid coverage. The county administered general assistance (GA) medical program identifies these low-income persons whenever they apply for general assistance from the county. The county determines a person's low-income status under financial income criteria similar to or more restrictive than eligibility income criteria for the Wisconsin Medicaid program (WMP). The county also tabulates charges for hospital services provided persons covered by the county's GA medical program and provides an annual report to the WMP. The WMP uses this information in its calculation of this DSH allowance. A major urban county is a county with 500,000 or more population.

The special payments described in this section 8200, specifically subsections 8310 through 8360, are disproportionate share hospital payments provided in accord with the federal Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923.

8310 Qualifying Criteria.
If above ICA provisions are met, a hospital is a disproportionate share (DSH) hospital and qualifies for general assistance disproportionate share hospital payments (GA-DSH) if the hospital meets all the criteria below.

a) The hospital meets the obstetrician requirements of §5242.
b) The hospital has a Medicaid inpatient utilization rate of at least 1% determined under §8130.
c) The hospital or its parent corporation has a contract with the county government to serve low-income persons covered by the county's general assistance program.
d) The ICA provisions described in the first paragraph of this section 8300 are met.

For a hospital to qualify as a DSH hospital under this § 8300, the hospital is <u>not required</u> to meet the qualifying criteria for DSH under § 8200. In contrast, a hospital that qualifies as a DSH hospital under this §8300 can qualify for the DSH adjustment under § 8200 if, and only if, the hospital meets the qualifying criteria of § 8200.

8320 Amounts of GA-DSH Allotment and Payments

The amount of the GA-DSH allotment, when combined with all other DSH payments under the Plan, shall not exceed the State DSH allotment for Wisconsin for the relevant fiscal year, as published by CMS pursuant to § 1923(f) of the Social Security Act [42 USC § 1396r-4(f)]. The Department will establish a methodology for distributing the GA-DSH allotment under this section among qualifying hospitals such that the amount of the GA-DSH payment to each hospital in any year, when combined with any other DSH payment to the hospital, results in a total DSH payment that is not greater than the hospital's uncompensated costs for that year as determined under § 1923(g)(1)(A) of the Social Security Act [42 USC § 1396r–4(g)(1)(A)] or less than the hospital's minimum payment adjustment under the tests set forth in § 1923(c) of the Social Security Act [42 USC § 1396r–4(c)].

The GA-DSH funding is distributed among qualifying hospitals.

First, total charges are tabulated for each respective hospital for inpatient and outpatient services provided persons eligible for a county GA program in the calendar year prior to the July 1 rate year.

Second, these charges are multiplied by a ratio of cost-to-charges of the respective hospital resulting in a hospital-specific GA service cost.

Third, the hospital-specific GA service cost of all qualifying hospitals is summed.

Fourth, the maximum GA-DSH funding divided by this sum of hospital-specific GA service costs results in a ratio of funding-to-costs.

Fifth, the ratio of funding-to-costs multiplied by the GA service cost of each qualifying hospital results in the annual GA-DSH allowance for each hospital and a proportional distribution of the GA-DSH funding among qualifying hospitals. The ratio of funding-to-costs is not to exceed 1.00 in order that the total of the GA-DSH allowances do not exceed total GA service costs of the qualifying hospitals.

Sixth, this annual amount is paid to the respective qualifying hospitals.

8330 Combining Historical Financial Statistics for Recent Hospital Combinings

Hospital combinings result from hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant.

When hospitals combine into one hospital, the required years of historical data may not be available for the combined operation for one or more rate years after the combining occurs. Whenever a required year of data is available for a full year of the combined hospital operation, then that year of data is used. However, if a full year is not available for the combined operation, then data of the individual hospitals for the required years is combined or added together for the calculations under §8210 through §8250.

SECTION 8500
Pediatric Inpatient Supplement

Supplemental payments are provided to acute care hospitals located in Wisconsin which provide a significant amount of services to persons under age 18. The payments will be subject to the payment limitation of section 9000 by which the total of the overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.

8510 Qualifying Criteria for Pediatric Inpatient Supplement

A hospital qualifies for this pediatric supplement if the hospital meets the following criteria.

1) The hospital is an acute care hospital located in Wisconsin.
2) During the hospital's fiscal year described here, inpatient days in the hospital's acute care pediatric units and intensive care pediatric units of the licensed facility totaled more than 12,000 days. Days for stays in neonatal intensive care units are not included in this determination. The inpatient days are counted for the hospital's fiscal year that ended in the second calendar year preceding the beginning of the rate year. For example, for the rate year beginning July 1, 1998, the hospital's fiscal year that ended in 1996 is used.

8515 Determination of Supplemental Payment

The pediatric inpatient supplement is paid as a monthly amount established according to the following method. A total of $2,000,000 is distributed each rate year among hospitals qualifying for this supplement. This is distributed proportionately among qualifying hospitals based on their number of Medicaid pediatric days as described below.

A qualifying hospital's pediatric inpatient supplement will be determined as follows:

$$\text{Hospital's annual pediatric supplement} = \frac{\text{Medicaid pediatric days for hospital}}{\text{Sum of Medicaid pediatric days of all qualifying hospitals}} \times \$2{,}000{,}000 \text{ Statewide annual funding}$$

$$\text{Hospital's monthly pediatric supplement} = \frac{\text{Hospital's annual pediatric supplement}}{12 \text{ Months}}$$

Medicaid pediatric days for the above calculation are a hospital's total covered inpatient days for pediatric Medicaid recipients, including HMO covered pediatric Medicaid recipients, for patient discharges occurring in the rate year that began two years prior to the beginning of the current rate year. (For example, for a current rate year beginning July 1, 1998 the rate year July 1, 1996 through June 30, 1997 is used.) A pediatric patient is a patient that has not attained 18 years of age as of the day of admission. Medicaid pediatric days do not include: (a) days of Medicaid recipient stays that are covered in full or part by Medicare; and (b) days of Medicaid covered stays on which Medicaid made no payment due to the stay being covered by some other payer such as private hospitalization insurance.

SECTION 9000
PAYMENT NOT TO EXCEED CHARGES

The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges-plus-disproportionate share, in aggregate, for inpatient hospital services provided to WMAP recipients. Overall payments from all sources includes, but are not necessarily limited to, WMAP payments, recipient co-payments, third party liability payments, local and related matching FFP amounts under §8000 and the indigent care allowance of §8230. The state fiscal year is July 1 through June 30. Disproportionate share (under sections 5180 and 8250) in the WMAP payment rates will be added to the allowable charges.

If an individual hospital's overall payments for the period exceed charges-plus-disproportionate share, the WMAP will recoup payments in excess of charges-plus-disproportionate share.

SECTION 9100
LIMIT ON AMOUNT OF DISPROPORTIONATE SHARE PAYMENT TO A HOSPITAL

A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for MA recipient services and the unrecovered cost of uninsured patients. The amount of disproportionate share payments which exceed this limit shall be determined retrospectively after a hospital completes its fiscal year. (Statutory Background. Section 1923(g) of the federal Social Security Act.)

Payment Shortfall for MA Recipient Services. The payment shortfall for MA recipient services is the amount by which the costs of inpatient and outpatient services provided MA recipients exceed the payments made to the hospital for those service excluding disproportionate share hospital payments. Disproportionate share hospital payments are payments provided a hospital under the State of Wisconsin Medicaid State Plan according to the provisions of the Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923. If payments exceed costs, the financial gain from MA payments will be applied against the uncompensated care costs for the uninsured.

The cost will be established by multiplying charges for inpatient and outpatient services by a ratio of costs to charges for patient care services. The ratio will be determined from the most current audited Medicaid cost report on file with the Department. Services provided MA recipients covered by an HMO under the WMAP will be included.
For outpatient MA services, interim outpatient payments limited to charges for the hospital's fiscal year will be used. For inpatient MA services, payments limited to charges will be also used. Payments limited to charges will be the lesser of (a) charges made by the hospital during its fiscal year for MA services, or (b) overall payments from all sources (as defined in §9000) for MA services during its fiscal year, excluding disproportionate share payments. This charge limit will be applied separately to payments for inpatient services and payments for outpatient services for the period of the hospital's fiscal year.

Unrecovered Cost of Uninsured Patients. The unrecovered cost of uninsured patients is the amount by which the costs of inpatient and outpatient services provided to uninsured patients exceed any cash payments made by them. However, as provided in the Social Security Act, Section 1923(g)(1)(A), “For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government with a State shall not be considered to be a source of third party payment.”

If payments exceed costs, the financial gain from payments for the uninsured will be applied against the MA shortfall. An uninsured patient is an individual who has no health insurance or source of third party payment for the services provided by the hospital. The cost will be established by multiplying charges for inpatient and outpatient services by a ratio of costs to charges for patient care services. The ratio will be determined from the most current audited Medicaid cost report on file with the Department.

Recovery of Excess Disproportionate Share Payments. If total disproportionate share payments to the hospital for services provided during its fiscal year exceed the sum of the payment shortfall for MA recipient services and the unrecovered cost of uninsured patients, then the excess disproportionate share payments will be recovered from the hospital.

Administrative Adjustments. A hospital may request an administrative adjustment under section 11900, item N, if an amount is to be recovered. The hospital or the Department may initiate an administrative adjustment under item O after completion of the outpatient final settlement for the hospital's fiscal year.

Effective Date. This limitation applies only to hospitals owned or operated by a State or by a unit of local government beginning July 1, 1994. With respect to hospitals that are not owned or operated by a State or unit of local government, this limitation applies beginning July 1, 1995 unless the federal Department of Health and Human Services exempts such hospitals or modifies the limitation for them.

For hospitals with fiscal years in progress (not beginning) on July 1, 1994 (or July 1, 1995 if applicable), the MA shortfall and the unrecovered cost of uninsured for the fiscal year will be prorated between the period before July 1 and the period on and after July 1 based on the proportion of disproportionate share payments applicable to each period.

SECTION 10000
PAYMENT FOR SERVICES PROVIDED IN HOSPITALS OUT-OF-STATE
HOSPITALS NOT HAVING BORDER-STATUS AND MINOR BORDER STATUS HOSPITALS

10100 INTRODUCTION

Minor border status hospitals and out-of-state hospitals which do not have border status will be paid according to the DRG based payment system described in this section 10000. This payment system provides a single base DRG base rate for all minor border status and non-border status hospitals. This rate is applied to the DRG weights which have been developed for use under section 5000 for in-state hospitals and major border status hospitals. The rates do not consider hospital-specific costs or characteristics as is done for in-state and major border status hospitals.

For any out-of-state hospital, border status or not, certain services will not be reimbursed according to the DRG methodology if the hospital takes the necessary action to receive reimbursement under an available alternative payment. These services and their alternative payment method are described in section 7000 and include AIDS care, ventilator patient care, special unusual cases and brain injury care.

For questions and additional information, out-of-state hospitals may contact the Department at: Division of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701-0309; telephone (608) 261-7838.

Any pre-established standard payment amounts which are described below and the DRG weighting factors for the current state fiscal year, July 1 through June 30 may be requested from the above address.

10200 DRG BASED PAYMENT SYSTEM
(For Minor Border Status and Non-Border Status Hospitals)

10210 Base DRG Rate

The base DRG rate for all minor border status and non-border status hospitals shall be 75% of the budget-adjusted average DRG base rate for in-state Wisconsin acute care hospitals under the methodology described in section 5000. Minor and non-border status hospitals are also eligible for the disproportionate share rate add-on described in section 5180

10230 Cost Outliers

Minor border status hospitals and non-border status hospital claims may qualify for cost outlier claims.

The cost outlier trimpoint for all out-of-state hospital claims will be that trimpoint amount per discharge which is provided to general medical/surgical hospitals of 100 or greater beds in Wisconsin. The variable cost ratio for costs above the trimpoint will be .77.

10300 PAYMENT NOT TO EXCEED CHARGES

For out-of-state hospitals not having border-status, payment on each discharge may not exceed the hospital's charges for allowable services. This limit applies to discharges paid under the DRG based payment system and to payment for services exempt from the DRG payment system.

For minor border-status hospitals, payments are limited to charges according to the method described in section 9000. This method limits aggregate annual payments to charges, not by individual claims.

10400 ADMINISTRATIVE ADJUSTMENT ACTIONS
(For Minor Border Status Hospitals and Non-Border Status Hospitals)

10410 Introduction. Administrative adjustment actions provide hospitals with a procedure to have payments for WMAP recipient stays adjusted for many of the hospital-specific adjustments which are routinely provided to hospitals in Wisconsin and to major border status hospitals. Most of the adjustments require the hospital to submit an audited Medicare cost report or other information. The administrative adjustment provisions in section 11000 are not available to minor border status hospitals and non-border status hospitals.

10415 Reduced Payment Possible. If an administrative adjustment results in a lesser payment than would have been provided had no administrative adjustment been requested, the lesser amount will be paid by the Department. If an administrative adjustment results in an increased payment, the increase shall be paid by the Department.

10420 Request Due Date and Adjustment Effective Date. A hospital must submit a written request to the Department for an administrative adjustment. The request must be delivered within 60 days after the date of a written notice from the Department notifying the hospital of its payment rate in order for the rate to be adjusted retroactively to its original effective date. If the Department had not previously provided written notice to the hospital of the payment rate, the hospital must deliver a written request within 60 days after the date of the WMAP's remittance check to the hospital for payment of a WMAP recipient's stay. If the request is delivered after the 60 day period, then the requested adjustment may be effective on the first of the month following the month in which the request has been delivered. Delivery date is defined in §11610.

The request must specify which of the adjustments described in subsection 10461 through 10469 below are desired. Written requests are to be sent to: Hospitals, Physicians and Clinics Section, Division of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701-0309.

10440 Effective Period. Administrative adjustments provided by the Department to any out-of-state hospital shall be effective for the rate year for which the adjustment is approved effective. A rate year encompasses the twelve month period July 1 through June 30. The adjustment shall not apply for payment of WMAP recipient discharges in previous or subsequent rate years.

> **Effective Period.** For example, a hospital requested a capital payment adjustment under §10464 for a recipient's discharge which occurred on January 23, 1996. The hospital discharges two more WMAP recipients on May 22 and June 3 respectively. The Department will apply the capital payment adjustment to payment of these later discharges. In this example, however, a new rate year will begin on July 1, 1996 and the hospital's capital payment adjustment will lapse. The hospital will need to again request the administrative adjustment for WMAP recipient discharges occurring in the new rate year.

10460 CRITERIA FOR ADMINISTRATIVE ADJUSTMENTS
(For Minor Border Status and Non-border Status Hospitals)

10465 Disproportionate share adjustment applied to payments.

A hospital may request a disproportionate share adjustment to its payment if it qualifies under the provisions of section 5180. The amount of the adjustment will be determined as is provided in section 5180. The hospital will have to submit verifiable patient day data for determination of the adjustment.

10467 Facility-specific cost-to-charge ratio for use in outlier payment calculation

A hospital may request use of its facility-specific cost-to-charge ratio for use in the calculation of outlier claim payments. The hospital must submit a copy of its audited Medicare cost report for its most recent fiscal period for which an audit has been completed. The Department will calculate the hospital's Medicaid cost-to-charges ratio from information in the audited cost report and related Medicaid utilization. If the hospital has no audited cost report, then the hospital must submit a copy of its most recently completed unaudited cost report. The Department has the option to not accept the unaudited cost report and to withhold any administrative adjustment action until an audited cost report is available.

10468 Per Diem Rate for Out-of-State Rehabilitation Hospitals

A minor border status hospital or a non-border status hospital which qualifies as a rehabilitation hospitals may request to be exempted from DRG based payment and paid under a rate per diem. The rate per diem to be paid shall be an average of the rates being paid to other rehabilitation hospitals located in Wisconsin at the time of the MA recipient's admission, not including rates being paid new rehabilitation hospitals during a start-up period. If a rate being paid to a rehabilitation hospital is adjusted as is called for in step 1 of §6310, the statewide average rate will not be recalculated and adjusted for the out-of-state hospital until the July 1 subsequent to the patient's admission. (Payment rates are customarily adjusted each July 1 for all hospitals.) A rehabilitation hospital is a hospital that provides intensive rehabilitative services for conditions such as stroke, brain injury, spinal cord injury, amputation, hip fractures and multiple trauma to at least 75% of its patient population.

SECTION 11000
ADMINISTRATIVE ADJUSTMENT ACTIONS
For Hospitals In Wisconsin and Major Border Status Hospitals

11010 Introduction. The Department provides an administrative adjustment procedure that allows individual hospitals an opportunity to receive prompt administrative review of payment rates for those special circumstances and occurrences which meet the criteria described in §11900 below. It is up to a hospital to request an administrative adjustment or the Department to initiate an administrative adjustment.

Department staff review a request for an adjustment and determine if it should be denied or approved and, if approved, the amount of adjustment. If the hospital disputes the staff determination, the administrative adjustment request can be forwarded for review to the Administrative Adjustment Committee (AAC). The AAC provides a recommendation to the Department regarding the disputed adjustment. A detailed description of the policies and procedures for processing administrative adjustments is in Appendix §28000.

A hospital may file a Chapter 227 appeal regarding the Department's final decision. The appeal would be filed in accordance with the requirements of Chapter 227, Wis. Stats..

The payment rate for a hospital covered by the DRG based payment system is a schedule of several distinct components which, when applied, result in a total payment for services provided by a hospital to MA recipients. An administrative adjustment may involve the adjusting of one or more of these components.

The per diem rate for hospitals paid under a per diem rate at §6000 may have that rate adjusted through administrative adjustment actions described §11900 below. Administrative adjustment actions are not applicable to AIDS rates at §7100 and ventilator-assistance rates at §7200.

This §11000 applies only to in-state hospitals and major border status hospitals. Administrative adjustment actions for minor border status hospitals and non-border status hospitals are described in §10400.

11100 Hospital's Submission of Request for Adjustment.

A hospital must deliver a sufficient written request to the Department for an administrative adjustment. In order to be considered sufficient, the following items must be clearly identifiable in the written request: (1) that the request applies to its inpatient rate, *(2)* the effective date of the rate for which an adjustment is being requested, and *(3*) the specific administrative adjustment, circumstances or occurrences described in §11900 for which the hospital is making its request for an adjustment. The Department may, at its discretion, pursue clarification of an incomplete request and ask the hospital to submit a sufficient request.

A hospital needs to deliver a separate administrative adjustment request for each rate year. A rate year encompasses the twelve month period July 1 through June 30.

Requests should be addressed to:

Division of Health Care Financing
1 W. Wilson Street, Room 350
P. O. Box 309
Madison, Wisconsin 53701-0309.

The FAX telephone number is (608) 266-1096 but may change without notice.

11120 Due Date of Request and Effective Date of Adjustment.

The due date of a sufficient request and the effective date of any adjustment is described under each of the administrative adjustments listed in §11900.

For most but no all administrative adjustments, the “60 day rule” described in §11600 below will apply. To summarize the 60 day rule, if a request is delivered to the Department with 60 days of a rate notice from the Department, then the adjustment can be effective retroactively. If delivered after 60 days, the adjustment may be effective prospectively.

11150 Initiation of Adjustment by Department.

The Department may initiate an administrative adjustment. The Department will notify the hospital in writing that it has initiated an administrative adjustment. The effective date of the adjustment will be established according to "the 60 day rule" described in §11600 below.

11200 Reduced Payment Possible.

If an administrative adjustment results in a lesser payment than would have been provided had no administrative adjustment been applied, the lesser amount will be paid. If an administrative adjustment results in an increased payment, the increase shall be paid.

11300 Withdrawal.

Once Department staff has calculated the adjustment requested by a hospital and notified the hospital of the results, whether an interim or final adjustment, the hospital cannot withdraw its request for the administrative adjustment. The Department cannot withdraw an administrative adjustment it initiated after it has notified the hospital according to §11150.

11500 Effective Period of an Administrative Adjustment.

The effective period of any adjustment is described under each of the administrative adjustments listed in §11900. Most but not necessarily all administrative adjustments will be effective through the end of the rate year in which the administratively adjusted payment rate is effective and will expire at the end of that rate year. A rate year encompasses the twelve month period July 1 through June 30.

> For example, a hospital was notified of its July 1, 1993 rate in a notification from the Department dated July 7, 1993. On August 16, 1993, the hospital delivered a request for an administrative adjustment to its rate. According to the 60 day rule, the Department may approve the adjustment retroactively effective to July 1, 1993. The adjustment will expire after June 30, 1994. For its new rate effective July 1, 1994, the hospital must submit a new administrative adjustment request.

The Department may modify the amount of the administrative adjustment when the criteria below calls for such a modification or when the Department finds that there was an inappropriate calculation of the payment rate and/or an adjustment to the payment rate.

11600 The 60 Day Rule.

The effective date of an administratively adjusted payment rate shall depend on when the hospital requests the adjustment or the Department initiates the adjustment. For most but not all administrative adjustments, the effective date shall be established according to the following subsections.

11610 Definition, "Delivery date".

The U.S. Postal Service postmark date will be considered delivery date of a mailed administrative adjustment request. If delivered by FAX machine, the in scripted date from the Department's FAX machine shall be considered delivery date. Delivery date under any method, other than U.S. mail or FAX, shall be the day the Department receives delivery.

Delivery Date Continued

The Department is not responsible for written requests which are lost in transit to the Department. If lost, the hospital must demonstrate to the satisfaction of the Department that a "delivery date" had been established according to the above criteria. The Department recommends that hospitals use registered return-receipt U.S. mail in order that they have documentation of the postmark date and that the Department received the request.

11620 Definition, "Final rate notification".

A final rate notification, or a final notification of the rate, is a written notice to a hospital from the Department which lists one or more changed components of the hospital's rate schedule and which includes notice that the hospital has 60 days to request an administrative adjustment.

11630 Requested by Hospital Within 60 Days After Rate Notification.

A hospital must deliver a written request for an administrative adjustment *within the 60 day period* after the date of a final rate notification from the Department in order for the requested adjustment to take effect *on the original effective date* of the rates being adjusted. (See example in §11500.) The Department's notice of the adjusted rate does not start a new 60 day period.

11640 Requested by Hospital After 60 Days From Rate Notification.

If a hospital delivers a written request to the Department for an administrative adjustment *more than 60 days* after the date of a final rate notification from the Department, then any adjusted rate which results from the administrative adjustment request shall take effect on the *first of the month following the delivery date*. The Department's notice of the adjusted rate does not start a new 60 day period.

If "the first of the month following the delivery date" is in a new rate year, the request will be denied. This means that an administrative adjustment request with a delivery date after May 31 of the rate year will be denied.

> For example, August 3, 1993 was the date of a hospital's final rate notification for its rate effective July 1, 1993. On June 3, 1994 the hospital delivered a request for an administrative adjustment to its July 1, 1993 rate. According to the above 60 day rule, the adjustment would be effective July 1, 1994 which is the first of the month following the deliver date of the request. However, the request will be denied because July 1, 1994 is the beginning of a new rate year. It should be noted that the hospital may resubmit the administrative adjustment request specifically for its new July 1, 1994 rate.

11650 Requested by Hospital Before New Rate Year Begins.

A hospital may wish to request an administrative adjustment before a new rate year begins. Such requests will only be accepted if delivered to the Department *on or after the May 1* date preceding the beginning of the new rate year. A new rate year begins every July 1. When a hospital receives its new rate notification from the Department, it should verify that the new rate includes the requested adjustment.

11660 Administrative Adjustments Initiated by the Department.

If the Department initiates the adjustment within 60 days after the date of a final rate notification, the adjustment shall take effect on the original effective date of the rates being adjusted. If the Department initiates the adjustment more than 60 days after the date of a final rate notification, the adjustment shall take effect on the first of the month following the date on which the Department initiates the adjustment. The date the Department initiates the adjustment is the date of the written notification which is provided to the hospital according to §11150. A new 60 day rule period shall be allowed the hospital commencing with the date of notification to the hospital of the adjusted rate if the Department's adjustment causes a reduction of reimbursement.

The Department may initiate an administrative adjustment when it establishes a hospital's rate for a new rate year and include the adjustment in the Department's rate notification to the hospital.

11670 Correction of Inappropriate Calculations. The Department may find an inappropriate calculation of a hospital's rate coincident with its processing a hospital's administrative adjustment, whether requested by the hospital or initiated by the Department. An inappropriate calculation of rates is defined in §11900-A. The Department's correction of the inappropriate calculation will be effective the date the administrative adjustment is effective. If a requested adjustment is denied, the correction of the inappropriate calculation found by the Department will be effective the date the requested adjustment would have been effective had it been approved. A new 60 day rule period shall be allowed the hospital commencing with the date of notification to the hospital of the corrected rate if the correction causes a reduction of reimbursement.

For example, the adjustment requested by a hospital provided a $10 rate increase. An inappropriate calculation found by the Department caused a $2 decrease. Even though the net effect is an $8 rate increase, the isolated effect of the Department's correction caused a $2 decrease. As a result, the hospital will have a new 60 day period for requesting an administrative adjustment.

11900 CRITERIA FOR ADMINISTRATIVE ADJUSTMENT ACTIONS

For In-State Hospitals and Major Border Status Hospitals

Requests for an administrative adjustment may be submitted by hospitals for one or more of the following specific circumstances or occurrences.

A. Correction of Inappropriate Calculation of Rates

Qualifying Determination: One or more components of the payment rate schedule must have been inappropriately calculated under the rate setting plan. An inappropriate calculation is:

(1) The application of the rate setting methodology or standards to incomplete or incorrect data contained in the hospital's cost report or to other incomplete or incorrect data used to determine the hospital's payment rate, or
(2) A clerical error in calculating a component of the hospital's payment rate schedule, or
(3) Incorrect or incomplete application by the Department of provisions of the rate setting methodology or standards in determining one or more components of the hospital's payment rate schedule or in determining any administrative adjustment of a hospital's payment rate schedule.

(Note that the rate setting methodology and standards are specified in attachment 4.19A of the State Plan.)

Request Due Date and Effective Date: The 60 day rule applies per §11600 above. For rate calculation corrections initiated by the Department, the 60 day rule does not apply if data is corrected which has not been audited by the Department or by an agent of the Department for the Wisconsin Medical Assistance Program. Any resulting corrected rates may be retroactively effective to the original effective date of the rate being corrected.

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. (Reference §11500 above.)

Adjustment Procedure: The hospital must supply data or information to the Department to support an adjustment. The data must be able to be audited currently or at a later time by the Department. An audited cost report of the hospital may need to be reopened in order to resolve the adjustment request.

Reopening Audited Cost Report: Either the hospital or the Department may request that the Medicaid audit contractor reopen an audited cost report. An audited cost report may be reopened only if all of the following conditions are satisfied: (1) the dollar effect is $5,000 or greater, (2) the statistic affecting the payment rate is in error by 5% or more, and (3) the request for reopening and the necessary data is submitted to the audit contractor within five years from the end date of the cost reporting period for which the cost report is being reopened. The audit contractor will apply these conditions.

The Department may request that the audit contractor obtain additional data or perform additional audit tests when reopening a cost report. The audit contractor's charge to the Department for reopening a cost report may be billed to the provider if it was the provider's error that was in need of correction.

Legal Review Pursued by Hospital: Corrections of payment rate calculations must be pursued by a hospital through this administrative adjustment before the hospital can pursue legal review of its rate calculation. If a hospital does pursue any available legal review after requesting an administrative adjustment, the Department will withdraw any proposed rate adjustment as to any given issue it has offered to the hospital, and the Department will not put the adjusted payment rate into effect. If the adjusted payment has been put into effect and is an increase over the payment previoulsy in effect, the adjusted payment will be retroactively rescinded to the date it was effective and replaced with the payment in effect prior to the adjustment. In such a case, increased payments at the adjusted rate will be recovered by the Department.

B. Use More Current Cost Report If Available Cost Report Is More Than Three Years Old

A hospital's audited cost report which is on file with the Department is the basis for determining: the provider specific, cost based DRG rate under §5100 and the cost to charge ratio for outlier payments under §5200.

If any of the payment components are based on an audited cost report period which is more than three years old, this administrative adjustment allows an adjustment of all of the above payment factors based on a more current audited cost reporting period. All factors requiring cost report data will be adjusted with no option by the hospital or the Department to elect to adjust only some of the payment factors. The reimbursement a hospital receives may increase or decrease as a result of using the more current cost report data.

Qualifying Determination: The end date of the period of the audited cost report used by the Department for establishing any component of a hospital's specific payment rate precedes the effective date of the payment rate by more than three years and three months.

For example, for a hospital's payment rates effective July 1, 1994, the Department used the hospital's audited cost report for its fiscal year ended December 31, 1990. Back-up 3 months from July 1, 1994 to April 1, 1994 and then subtract 3 years from 1994 resulting in a date of April 1, 1991. The hospital would qualify because its cost report used for establishing payment rates ended before April 1, 1991.

Request Due Date and Effective Date: The 60 day rule applies per §11600 above.

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted payments are effective. A rate year ends each June 30th. (See §11500 above for more detail.)

Definition, Updating Fiscal Year: The *updating fiscal year* is the first fiscal year of the hospital which ended on or after date three years and three months prior to the effective date of the payment rates.

For example, a hospital has a fiscal year ending September 30. The hospital's rate effective July 1, 1994 was based on its September 30, 1990 fiscal year cost report. Its updating fiscal year would be its fiscal year, which ended September 30, 1991. (The reference date was calculated by backing-up 3 months from July 1, 1994, to April 1, 1994 and then subtracting 3 years from 1994.)

Interim Adjustment: The audited cost report for the updating fiscal year may not be available at the time a hospital requests this administrative adjustment. The Department may provide interim adjusted payment amounts until the cost report is available. Upon consultation with the Department, the hospital must provide the Department sufficient information in order that the interim adjustment is a reasonable and reliable estimate of the final expected capital and direct medical education payment rates, the disproportionate share adjustment, the outlier cost to charge ratio, and the rural adjustment.

Final Adjustment: After the Department receives an audited Medicaid cost report for the updating fiscal year, all four payment factors will be calculated and adjusted based on the audited data, specifically: (1) the disproportionate share adjustment, (2) the capital payment, (3) the direct medical education payment, (4) the hospital's cost to charge ratio for outlier payments, and (5) the rural adjustment. The payment amounts will be determined according to the rate setting methodology that was in effect for the period for which the final adjusted payment amounts are to be effective. A recoupment or payout will be made for the period for which the final adjusted payment factors apply.

C. Recalculation of DSH Cost Limitation of §5180 With Additional Information

Qualifying Determination: If the Department determines that all or a portion of the disproportionate share (DSH) payments made to a hospital during its fiscal year are to be recovered under §5180, then the hospital may request a recalculation of the recovery amount based on alternative or additional information.

Request Due Date: The request for this administrative adjustment must be delivered to the Department within a due date specified in a letter from the Department to the hospital in which it is notified of the amount to be recovered.

Adjustment Procedure: The Department will recalculate the disproportionate share payment limitation under §5180 after the hospital has provided alternative or additional information acceptable to the Department for use in the recalculation. The Department may require the information to be provided within a limited period.

D. Recalculation of DSH Cost Limitation Upon Settlement of Outpatient Reimbursement.

Qualifying Determination: The hospital or the Department may initiate a recalculation of the disproportionate share (DSH) limitation of §5180 for the hospital's fiscal year at the time of settlement of outpatient reimbursement for the fiscal year.

Request Due Date: The hospital's request for this administrative adjustment must be delivered to the Department within a due date specified in a letter from the Department to the hospital in which it is notified of the outpatient reimbursement settlement.

Adjustment Procedure: The Department will recalculate the disproportionate share payment limitation under §5180 taking into account the outpatient reimbursement settlement.

E. Claim Adjustment For Length Of Stay Outlier

Qualifying Determination: A hospital may request a calculation of a length of stay outlier payment adjustment.

Adjustment Procedure: The hospital must submit a claim for the stay to the Department's fiscal agent. The hospital must also submit a request for this administrative adjustment to the Department with a copy of the claim. The Department will determine if the claim qualifies for an adjustment and will calculate the amount of adjustment.

Hospitals should send requests for a length of stay outlier adjustment to: Hospitals, Physicians and Clinics Section, Division of Health Care Financing, P. O. Box 309, Madison, WI 53701-0309.

Request Due Date: The request for this adjustment must be delivered to the Department within 180 days after the date the recipient is discharged from the hospital. This due date applies without regard as to whether or not a claim for the stay has been paid by the Department's fiscal agent.

F. Adjustment For Hospital Expecting Payment To Exceed Charges

Qualifying Criteria: Section 9000 requires a retroactive recovery of payments when a hospital's overall payments for MA recipient services exceeds charges-plus-disproportionate share, in aggregate, for each state fiscal year period of July 1 through June 30. A hospital may request an interim decrease of its payment rate in order to avoid a significant recovery which it expects may result from accepting payment at its full allowed payment rate.

Continuation -- Payments to Exceed Charges

Adjustment Procedure: An interim payment rate will be established at a rate mutually agreeable to the hospital and the Department. After completion of the state fiscal year a final reimbursement settlement will be calculated. The charge limitation of §9000 will be applied using overall payments including payments at the interim rates. If the payments exceed the charges, the excess will be recouped. If the payments are less than charges, then the charge limitation of §9000 will be applied using overall payments calculated at the hospital's full allowed payment rate. The lesser of payments (a) at the full allowed rate, or (b) charges-plus-disproportionate share will be the final allowed reimbursement for the year. An additional payment will be made for the difference between the interim reimbursement and the final allowed reimbursement.

Request Due Date and Effective Date: This adjustment may be requested at any time with the interim payment rate effective prospectively.

G. Disproportionate Share Adjustment for New Hospital

Qualifying Determination: This administrative adjustment allows a new hospital to receive a disproportionate share adjustment for its initial years of operation to be based on its Medicaid inpatient day utilization for periods other than base cost report period specified in §5180.

Request Due Date and Effective Date: The 60 day rule per §11600 applies.

Expiration of Adjustment: The DSH adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. The hospital must submit a new request for this adjustment for each rate year which begins each July 1st. (Reference §11500.)

Definitions: A new hospital's *"initial years of operation"* begin the date the hospital admits its first WMAP recipient and ends the June 30th date following completion of the hospital's fourth full fiscal year after the fiscal year in which the first WMAP recipient was admitted. (For example, a hospital's fiscal year ends each December. It admitted its first WMAP recipient on May 9, 1994. Its fourth full fiscal year after the admission ends December 31, 1998. Its "initial years of operation" end June 30, 1999.)

Adjustment Procedure: The DSH adjustment will be determined according to §5180. For a "Medicaid utilization adjustment", the number of inpatient days for the calculation will not come from the base cost report specified in §5180. The first adjustment which a hospital requests will be based on inpatient day data from a period of at least six months which may begin before the facility was certified for the WMAP and before the first WMAP recipient was admitted but may not begin before the facility was licensed as a hospital. Disproportionate share adjustments for subsequent rate years (i.e., rate years after the rate year in which the first DSH adjustment was made) will be based on inpatient day data for an updated and more current period of at least six months.

The specific data reporting periods to be used will be specified by the Department after consultation with the hospital. The data may be audited at a later date and, if found to be in error, the Department will recover any overpayment that resulted.

H. Adjustment for Combining Hospitals

Sections 5360 and 6460 provide that, for recent hospital combinings, costs and patient days from the audited cost reports of each previous individual (i.e., before combining) hospital will be combined to calculate those components of the hospital payment rates which require the use of cost report data. Hospital combinings result from hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. Audited cost reports for the individual hospitals will be used until an audited cost report for the combined or absorbing hospital becomes available for the annual rate update. This administrative adjustment allows the combined or absorbing hospital to have its payments retroactively adjusted based on its audited cost report when they become available.

Continuation -- Combining Hospitals

Qualifying Criteria: The combined or absorbing hospital had those components of its payment rates which require cost report data based on the costs and patient days from the audited cost reports of the previous individual hospitals as provided in sections 5360 and 6460.

Request Due Date and Effective Date: The 60 day rule applies per §11600 above. The 60 day period applies to the notification of those rates which are based on the costs and patient days from the audited cost reports of each previous individual hospital.

> For example, hospitals A and B merged into hospital C on May 1, 1995 with C having a December fiscal year end. Hospital C is notified by the Department on May 10, 1995 of its payment rates which are based on the audited cost reports of A and B. The 60 day rule starts with this May 10th notification in order for the hospital to request its rates to be retroactively adjusted based on its audited cost report for its fiscal year ending December 31, 1995 when the audited cost report becomes available.

Expiration of Request: The initial request will cover all periods during which payment rates were based on the audited cost reports of the previous hospitals. (Section 11500 above does not apply to this adjustment.) The hospital may withdraw the request according to the provisions §11300.

Adjustment: When the merged or absorbing hospital's audited cost reports become available to the Department, the Department will recalculate those payment rate components which were based on the audited cost reports of the previous hospitals and which were in effect during the period of the merged or absorbing hospital's audited cost report. Based on the recalculated payment rates, a payout or recoupment will be made for the WMAP recipient services provided by the hospital during the cost report period.

> For example, hospital C's audited cost report for its first fiscal year, May 1 through December 31, 1995, became available in April 1996. Its payments for May through December 1995 will be retroactively adjusted based on this audited cost report even though it spans two WMAP rate years. (Also, because this audited cost report was received in April 1996, it will be used for the July 1, 1996 annual rate update and the use of previous hospitals' cost reports will be discontinued.)

I. Eligibility for Rural Hospital Adjustment Considering Days Provided Under Out-of-State Medicaid Programs and/or Governmental Programs Other Than Medicare and Medicaid

Qualifying Determination: This administrative adjustment allows the inclusion of out-of-state Medicaid days and days associated with other government programs in determining eligibility for the rural hospital adjustment of §5180. A hospital may request this administrative adjustment if it would qualify for the rural hospital adjustment according to the criteria provided in §5180.1 but does not qualify solely because its combined Medicare and Medicaid utilization is less than 55%.

Request Due Date and Effective Date: The 60 day rule per §11600 above applies.

J. Adjustment to Rural Hospital Adjustment Percentage for Substantial Increase in Medicaid Utilization.

Qualifying Determination: A hospital may request this administrative adjustment if it qualifies for the rural hospital adjustment according to §5180.1 and had a current Medicaid utilization which is at least 25% greater than the Medicaid utilization on which the hospital's rural adjustment was determined.

Request Due Date and Effective Date: The 60 day rule per §11600 above applies.

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. (Reference §11500 above.)

Adjustment Procedure: The hospital will need to furnish Medicaid inpatient days and total inpatient days from a current twelve month period which is acceptable to the Department. The inpatient days should exclude long-term care days from hospital swing-beds. The inpatient days may include the inpatient days of enrollees in Medicaid programs of states other than Wisconsin. The rural hospital adjustment percentage will be determined according to §5180.2 based on this new data. The data may be audited at a later date and, if the data is found to be in error, the Department will recover any overpayment that result from the erroneous data.

K. Adjustment to Rural Hospital Adjustment Percentage for Recognition of Out-of-State Medicaid Days

Qualifying Determination: A rural hospital may request this administrative adjustment to recognize inpatient days of enrollees of Medicaid programs other than the Wisconsin Medical Assistance Program (out-of-state Medicaid). A hospital may request this administrative adjustment if it qualifies for the rural hospital adjustment according to §5180.1.

Request Due Date and Effective Date: The 60 day rule per §11600 above applies.

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. (Reference §11500 above.)

Adjustment Procedure: The hospital will need to furnish out-of-state Medicaid inpatient days for the same reporting period of the Wisconsin Medicaid days which were used in establishing the rural hospital adjustment percentage. The rural hospital adjustment percentage will be determined based on a Medicare and Medicaid utilization rate which includes out-of-state Medicaid days. The data may be audited at a later date and, if the data is found to be in error, the Department will recover any overpayment that result from the erroneous data.

END OF SECTION 11000
ADMINISTRATIVE ADJUSTMENT ACTIONS

This page intentionally left blank.

Wisconsin Medicaid Program
Inpatient Hospital State Plan
Under Title XIX of the Social Security Act

Methods and Standards for Determining Payment Rates

***** **APPENDICES** *****

This page intentionally left blank.

21000 Example Calculation - Cost Outlier Payment

APPENDIX SECTION 21000

EXAMPLE CALCULATION – State of Wisconsin Acute Care Hospital (over 100 beds)
COST OUTLIER PAYMENT
Pursuant to Section 5220

BASE DATA

APPROVED BEDS	250
T-19 INPATIENT COSTS (Cost Report Source: Worksheet E-3 part III line 1)..	$2,669,763
T-19 INPATIENT CHARGES (Cost Report Source: Worksheet E-3 part III line 21) Divide by	$4,348,653
COST-TO-CHARGE RATIO FOR OUTLIER CALCULATIONS =	0.6139
(Ratio of T-19 inpatient costs to T-19 inpatient charges)	

EXAMPLE CALCULATION OF COST OUTLIER PAYMENT

1.	Allowable claim charges	$ 123,550
2.	Cost-to-charge ratio (see above)	X .6139
3.	Claim charges adjusted to cost	$ 75,847.35
4.	DRG Payment	($ 18,419.91)
5.	Claim cost exceeding DRG payment	$ 57,427.44
6.	Applicable trimpoint for hospital bed size	($ 50,000.00)
	(Trimpoints applicable to current rate year are listed in section 5320.1.)	

7. Decision: Does Line 5 -exceed- Hospitals Trimpoint at Line 6?
   _x_ Yes - Continue at Line 8
   ___ No - No outlier payment in addition to DRG payment

8.	Claim cost exceeding DRG payment and trimpoint =	$ 7,427.44
9.	Disproportionate share adjustment percentage (Note A) . X	1.043
10.	Adjusted variable cost factor X	1.043
11.	OUTLIER PAYMENT =	$ 7,746.82
12.	DRG PAYMENT +	$ 18,419.91
13.	TOTAL PAYMENT FOR CLAIM including outlier payment	**$ 26,166.73**

Note A -- If no disproportionate share adjustment applies to hospital, then a 1.00 multiplier is used.

For Line 4 above, example calculation of base DRG payment.

	Total
Hospital-Specific Base Rate	$ 6,540
Times: DRG Weight for stay	2.8165
Basic DRG Payment	$ 18,419.91

APPENDIX SECTION 21000

EXAMPLE CALCULATION – MAJOR BORDER STATUS HOSPITAL (over 100 beds)
COST OUTLIER PAYMENT
Pursuant to Section 5220

BASE DATA

APPROVED BEDS	142
T-19 INPATIENT COSTS (Cost Report Source: Worksheet E-3 part III line 1)..	$ 663,287
T-19 INPATIENT CHARGES (Cost Report Source: Worksheet E-3 part III line 21) Divide by	$1,036,753
COST-TO-CHARGE RATIO FOR OUTLIER CALCULATIONS =	0.6397

(Ratio of T-19 inpatient costs to T-19 inpatient charges)

EXAMPLE CALCULATION OF COST OUTLIER PAYMENT

1.	Allowable claim charges	$ 113,982
2.	Cost-to-charge ratio (see above)	X .6397
3.	Claim charges adjusted to cost	$ 72,914.29
4.	DRG Payment	($ 5,160.95)
5.	Claim cost exceeding DRG payment	$ 67,753.34
6.	Applicable trimpoint for hospital bed size	($ 50,000.00)

(Trimpoints applicable to current rate year are listed in section 5320.1.)

7. Decision: Does Line 5 -exceed- Hospitals Trimpoint at Line 6?
   _x_ Yes - Continue at Line 8
   ___ No - No outlier payment in addition to DRG payment

8.	Claim cost exceeding DRG payment and trimpoint	=	$ 17,753.34
9.	Variable cost factor	.77	
10.	Disproportionate share adjustment percentage (Note A) .	X 1	
11.	Adjusted variable cost factor		X .77
12.	OUTLIER PAYMENT	=	$ 13,670.07
13.	DRG PAYMENT	+	$ 5,160.95
14.	TOTAL PAYMENT FOR CLAIM including outlier payment		**$ 18,831.02**

Note A -- If no disproportionate share adjustment applies to hospital, then a 1.00 multiplier is used

For Line 4 above, example calculation of base DRG payment.

	Total
Hospital-Specific Base Rate	$ 4,430
Times: DRG Weight for stay	1.1650
Basic DRG Payment	$ 5,160.95

APPENDIX SECTION 22000
DISPROPORTIONATE SHARE ADJUSTMENT AMOUNTS

****

FOR SECTION 8130, MEDICAID UTILIZATION METHOD

A hospital's disproportionate share adjustment factor under section 5180 is calculated according to the following formula where:

S % = Medicaid inpatient utilization rate at one standard deviation above the statewide mean Medicaid utilization rate.

M = The hospital's Medicaid inpatient utilization rate for hospitals with a utilization rate greater than S%.

.26 = Linear slope factor allowing proportional increase in disproportionate share adjustment as utilization rate (M) increases.

Formula:

[(M -S%) X .26] + 3% = Hospital's Specific Disproportionate Share Adjustment Percentage for section 5180

(7/1/06, TN # 06-009)

****

FOR SECTION 8200, THE ESSENTIAL ACCESS CITY HOSPITAL (EACH) DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT

Annual Statewide Funding

The annual statewide funding for the essential access city hospital (EACH) disproportionate share hospital adjustment is $4,748,000.

(7/1/06, TN # 06-009)

****

FOR SECTION 8300, THE GENERAL ASSISTANCE DISPROPORTION SHARE HOSPITAL ALLOWANCE

Maximum Available Funding

For the rate year July 1, 2006 through June 30, 2007, and each rate year thereafter, the maximum available funding for the general assistance disproportionate share hospital allowance (GA-DSH) under section 8300 is up to an amount not to exceed $75,000,000.

APPENDIX 24000
PROCEDURES FOR PROCESSING ADMINISTRATIVE ADJUSTMENTS
For Inpatient and Outpatient Hospital Payments

The Department provides an administrative adjustment procedure that allows individual hospitals an opportunity to receive a prompt review of their payment rates for specific circumstances. The policies and criteria for administrative adjustments that apply to hospitals are provided in the following State Plan sections:

(1) For inpatient rates for hospitals in Wisconsin and major border status hospitals, see §11000 of the "Inpatient Hospital State Plan",
(2) For inpatient rates for minor border status hospitals and out-of-state hospitals, see §10400 of the "Inpatient Hospital State Plan",
(3) For outpatient rates, see §6000 of the "Outpatient Hospital State Plan".

This appendix outlines the procedures the Hospitals, Physicians and Clinics Section staff of the Division of Health Care Financing (we) will follow for processing administrative adjustment requests from hospitals. Under some circumstances, an interim administrative adjustment may be provided with a final adjustment calculated after the a required audited cost report is available. The procedures in this appendix apply to the calculation of interim and final administrative adjustments.

These procedures apply to any administrative adjustment request submitted by a hospital on and after July 1, 1996

24010 Receipt of Request For Administrative Adjustment

A request for an administrative adjustment must meet the following requirements:

(1) *The request must be submitted by the due date.* A due date is specified in the state plan sections listed above for each circumstance for which an adjustment may be requested.

(2) *The request must be sufficient*. The request must inform us:
  (a) as to whether the request applies to inpatient or outpatient rates,
  (b) the specific circumstance listed in the state plan for which the hospital is requesting an adjustment, and
  (c) the effective date of the rate to be adjusted or the outpatient final settlement period to be adjusted.

Upon receipt of a request for an administrative adjustment, we will review the request and, if necessary, contact the hospital regarding the following items:

(1) We will determine if the request was submitted by the due date. If not, we will notify the hospital either:
  (a) if the request is denied because it has not been submitted by the required due date, or
  (b) if "the 60 day rule" allows the adjustment to be effective at some date other than the effective date of the rate for which an adjustment is being requested. (The "60 day rule" is described in §11600 of the "Inpatient Hospital State Plan" and §6300 of the"Outpatient Hospital State Plan".)

(2) We will determine if the request is sufficiently clear. If not, we will contact the hospital for clarification and may ask the hospital to resubmit a sufficient request.

  (2) We will assess the data needed to calculate the adjustment. If additional data is needed from the hospital, we will request additional data according to the procedure described in §24020 below.

24020 Request For Additional Data

If we determine additional data is needed for the adjustment, we will contact the hospital to request the additional data and specify a due date for the hospital to submit it. The due date we specify will not be less than one month and not more than three months from the date of our request. However, if the hospital requests an extension and can justify that additional time is needed to provide accurate information, we may allow additional time for submitting the data.

If the hospital does not submit the data or an extension request within the specified time period, we will notify the hospital in writing that the administrative adjustment will be denied unless the hospital submits the requested data. With this notice, we will specify another due date for submitting the data of not less than two weeks and not more than one month from the date of this notice.

In order to calculate the administrative adjustment, we may find it necessary to request additional data more than once from the hospital. Each request for additional data will be handled as outlined above.

24030 Notification to the Hospital of Our Proposed Adjustment

After we have the needed data, we will calculate the adjustment and send a notification to the hospital of our proposed adjustment along with supporting worksheets.

We will request the hospital to review our proposed adjustment and respond only if the hospital disagrees with the calculations. We will specify a due date for a response of not less than one month and not more than three months from the date of our notification to the hospital of the proposed adjustment.

If the hospital responds with a disagreement to our calculations, we will attempt to settle the disagreement with the hospital as described in §28040 below.

If we do not receive a response from the hospital by the due date, we will deem our proposed adjustment accepted by the hospital and we will adjust the hospital's payment accordingly.

24040 If Hospital Disagrees With Our Proposed Administrative Adjustment

If the hospital disagrees with our proposed administrative adjustment, we will attempt to settle any disputes the hospital may have and reach an agreement. The process of settling disputes may continue until a mutual agreement is reached. It may involve our revising the adjustment one or more times. In the process of settling disputes, we may request additional data according to the procedures outlined in §24020 above.

24041 If We Do Not Revise the Disputed Adjustment.

If we do not revise the disputed adjustment, we will notify the hospital that no change will be made to the previously proposed adjustment. In this notification, we will inform the hospital that they can request a meeting with the administrative adjustment review panel and that such a request must be submitted by a due date that we will specify. (The panel is described in §24050 below.) The specified due date will not be less than one month and not more than three months from the date of this notice.

If we do not receive a request for a meeting from the hospital by the due date, we will deem our proposed adjustment accepted by the hospital and we will adjust the hospital's payment accordingly.

If the hospital requests a meeting with the review panel, we will contact the hospital to schedule a meeting.

We will not schedule a meeting with the administrative adjustment review panel until the hospital and us have attempted to reach an agreement on a disputed adjustment. We will schedule a meeting at the hospital's request only after the hospital has submitted a disagreement to our initial or first adjustment proposal and: (a) we have either responded to the hospital with at least one revised adjustment which they do not accept, or (b) we have notified the hospital that we will not change the proposed adjustment.

24042 If We Revise a Disputed Adjustment.

If we revise a disputed adjustment, we will send our revised adjustment and supporting worksheets to the hospital. With our proposing a revised adjustment, the procedures described in §24030 and §24040 above will be used for notifying the hospital and handling any disputes the hospital may have with the revision.

24050 Administrative Adjustment Review Panel

The administrative adjustment review panel serves as an advisory group to the administrator of the Division of Health Care Financing (DHCF) for final decisions on disputed administrative adjustments. The panel will be chaired by a designee of the director and will consist of at least four other staff of the DHCF. Panel members will be appointed by the director or his/her designee and will not necessarily be the same persons for each meeting or case. Up to two staff persons who are directly involved in hospital rate setting may be, but need not be, on the review panel. The staff person or persons who calculated the adjustment will not be on the review panel.

Meetings of the review panel will be scheduled with hospital consultation. The hospital's representatives may attend the meeting in person or may meet with the panel through a teleconference. In addition to meeting with the panel, the hospital's representatives may provide written position papers and other information regarding their case.

The meeting will be an informal fact finding meeting under the control and direction of the chairperson of the review panel. The DHCF staff person(s) who calculated the adjustment will explain their calculations and policy considerations and answer inquires from the panel and from the hospital's representatives. The hospital's representatives will be given the opportunity to present the hospital's case and answer inquires from the panel members and from the DHCF staff person(s) who calculated the adjustment. After hearing the presentations, the review panel will develop a recommendation for the director of the DHCF, which may include or be based on a revised calculation prepared at the direction of the panel. The panel may discuss the case without the presence of the hospital's representatives.

The DHCF administrator or his/her designee will make the final decision on the adjustment and will send notice of the decision to the hospital.

APPENDIX SECTION 25000

RURAL HOSPITAL ADJUSTMENT PERCENTAGES PURSUANT TO SECTION 5170

The following table lists the the rural hospital adjustment percentages that are applied under section 5170. The rural hospital adjustment percentage is that percentage corresponding to the range of utilization percentages in which the individual hospital's Medicaid utilization rate falls. For example, a Medicaid utilization rate of 7.34% falls in the "5.0% through 9.99%" range that has a corresponding 11% rural hospital percentage. Similarly, a 11.23% utilization rate corresponds to a 17% rural hospital percentage.

EFFECTIVE ON and AFTER JULY 1, 2001

Medicaid Utilization Rate	Rural Hospital Adjustment Percentage
Up through 4.99%	5.00%
5.0% through 9.99%	11.00%
10.0% through 14.99%	17.00%
15.0% and greater	23.00%

EFFECTIVE JULY 1, 2000 THROUGH JUNE 30, 2001

Medicaid Utilization Rate	Rural Hospital Adjustment Percentage
Up through 4.99%	8.00%
5.0% through 9.99%	17.00%
10.0% through 14.99%	26.00%
15.0% and greater	35.00%